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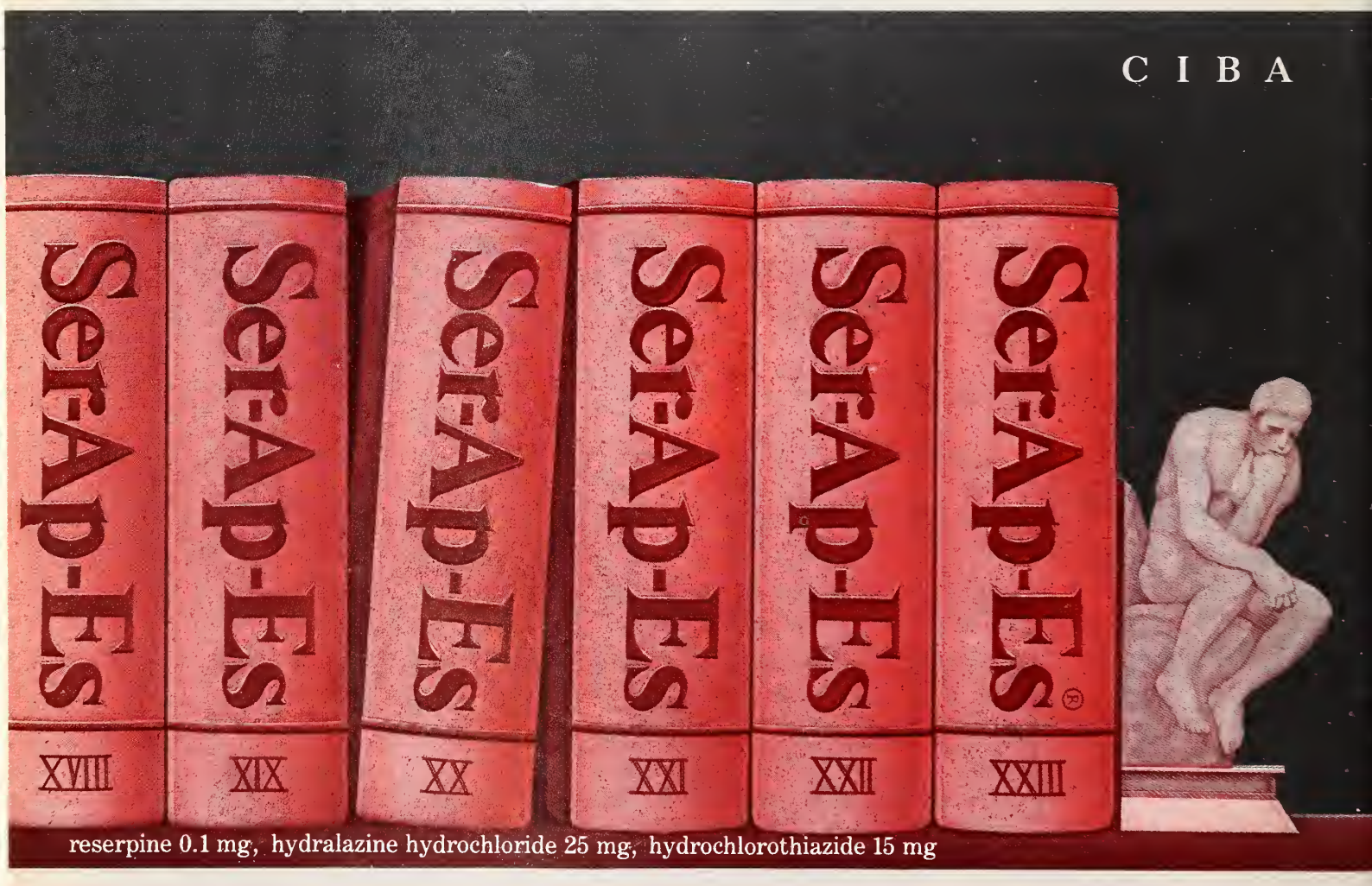
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Established 1911. Owned and edited by the Medical Association of Georgia. Published monthly under the direction of the Board of Directors of the Association. Printed by The Ovid Bell Press, Inc., Fulton, Missouri.

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The subscription price per year for members of the Medical Association of Georgia is $7.50, included in the annual membership dues. The subscription price for nonmembers is $15.00 in the United States, Canada and Mexico, and $17.00 in other countries. Single copies are $2.

The *Journal of the Medical Association of Georgia* is published monthly at 938 Peachtree Street, N. E., Atlanta, GA 30309-3990. Second-class postage paid at Atlanta, Georgia, and at additional mailing offices. POSTMASTER: Send address changes to Medical Association of Georgia, 938 Peachtree Street, N. E., Atlanta, GA 30309-3990.

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Incidental Intelligence . . .

Infant Mortality in a Rural Health District — Georgia

In 1979, the infant mortality rate (IMR) in a south Georgia health district, a rural, 16-county area covering 5,943 square miles with a population of 249,000, dropped and remained relatively low in 1980, compared with rates during the preceding 5 years. The number of births and deaths for infants born 1974-1978 and 1979-1980 were calculated for three birthweight categories: less than 1,500g, 1,500-2,499g, and 2,500g or greater. Although infants with birthweights greater than 2,500g had the lowest mortality rates, they represented 45% of deaths in 1974-1978 and 38% in 1979-1980.

To determine the components of the decline in IMR, a computerized registry of linked birth and infant-death certificates, maintained by the Georgia Department of Human Resources, was used.[1] The greatest relative decline in mortality occurred among infants with birth weights 1,500-2,499g and 2,500g or greater. If birthweight-specific neonatal and postneonatal mortality rates* for 1974-1978 had remained unchanged, 69 additional deaths would have been expected in 1979-1980 among infants with known birth weights. Nearly two-thirds (43/69) of the difference between observed and expected deaths occurred in the 2,500g or greater birthweight category. For infants 1,500-2,499g and 2,500g or greater, improvements during the neonatal and postneonatal periods were approximately equal, while for smaller infants, improvement was limited to the neonatal period. When specific causes of death were examined for infants 2,500g or greater, decreases in deaths due to infections and birth trauma/asphyxia/hypoxia contributed the most to the decline in neonatal deaths, and a decrease in deaths due to infections was the greatest contributor to the decrease in postneonatal deaths.

The IMR declined from 16.0 to 9.1 for white infants and from 30.4 to 19.1 for infants of other races, while the racial composition of births remained constant. The percentage of women delivering infants at high risk for neonatal death did not decrease.[2] Ninety-four percent of the decline in mortality was attributable to improved survival within birthweight categories, and 6% to a shift in the birthweight distribution.[3] The decrease in IMR was not associated with a parallel increase in admissions to intensive care units for newborns.

Reported by JT Holloway, Southeast Health Unit, Waycross, S Zaro, MPH, Family Health Svcs, RK Sikes, DVM, State Epidemiologist, Georgia Dept of Human Resources; Div of Field Services, Epidemiology Program Office, Div of Reproductive Health, Center for Health Promotion and Education, Birth Defects Br, Center for Environmental Health, CDC.

Editorial Note: Most of the recent decline in U.S. neonatal mortality has been attributed to improved survival of infants with birth weights lower than 2,500g.[4, 5] In this rural health district, where the IMR had been substantially higher than rates in the remainder of Georgia and the nation, most of the decline in infant mortality was due to improved neonatal and postneonatal survival for infants 2,500g or greater at birth. Within this group, decreases in neonatal mortality due to birth trauma/asphyxia/hypoxia may reflect improved intrapartum care, and decreases in neonatal and postneonatal deaths due to infections may reflect improved obstetric and infant care. Changes in IMR accompanied efforts to enhance basic prenatal, intrapartum, and postnatal services for women and infants. In 1975, this health district began a program providing routine prenatal and infant care as a precondition for receiving benefits from a nutrition program for mothers and infants. By 1979, the program was in effect in all 16 counties and enrolled approximately 30% of the district's pregnant women. Additionally, physicians in each county were identified who would offer low-cost obstetric care for high-risk, medically indigent women. However, it is not clear why the sharp drop occurred in 1979. Local and state health officials are conducting further studies to assess the contribution of participation in the supplemental nutrition program and other factors to the decline in infant deaths.

Linking birth and death certificates permits the use of maternal and infant characteristics at birth, particularly birth weight, in describing infant mortality. Analysis of birth weight, period-of-death, and cause-specific mortality rates forms a basis for implementing more appropriate strategies for preventing infant deaths and enhancing the evaluation of these programs.

* Neonatal mortality rate = deaths in infants < 28 days of age per 1,000 live births. Postneonatal mortality rate = deaths in infants 28 days to 1 year of age per 1,000 neonatal survivors.

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(*Reprinted in part from the* Morbidity and Mortality Weekly Report, *Vol. 32, No. 43, November 4, 1983, Graphic and tabular data omitted.*)

Letters to the Editor . . .

PPOs Debated

Dear Sir:

Dr. Underwood's article advocating the utilization of PPOs and other similar types of organizations with the suggestion that the physician advocate his role as manager of the team and assume his rightful position as first baseman, does injustice to the individual physician and to the profession of medicine. This type of reasoning fails to differentiate between the cost of "Health Care" and the cost of "Medical Care." The cost of medical care, which is dispensed by licensed physicians, makes up approximately twenty percent of the cost of the "Health Care" dollar.

Eighty percent of the cost is related to other ancillary people and facilities in that system. In spite of the assertions that physicians have direct impact upon this eighty percent of the cost, I suggest that our ability to directly change this system and its costs are miniscule.

Physicians can control their portion of the medical care costs agreeing *within* their organizations, such as hospital staffs and Medical Society memberships, that they will abide by specific guidelines of utilization and peer review as well as binding arbitration of contested fees.

The other part of the Health Care system which comprises hospitals and other such facilities, as well as Paramedical services, can be contracted for by third party payors that in a competitive environment could control cost. This contract would not interfere with the Physician-Patient relationship which is the "sine qua non" of the profession of medicine.

Medicine does have a responsibility of being the Captain of its own team, which is that of physician and patient. The Health Care industry can elect its own captain and players as the market place will allow.

If we do not understand this differentiation and begin to act accordingly, something else will be riding on our shoulder and it will not be a butterfly.

Sincerely,
S. Angier Wills, M.D., F.A.C.S.
Decatur

Dissent re Homosexuality

Dear Sir:

As physicians deeply concerned with issues of human rights, we regret the recent editorial [November, 1983] inappropriately entitled, "A Current Perspective on Homosexuality." It is not unusual to meet with prejudice in the practice of medicine, as in daily life, but to present such a viewpoint, at odds with prevailing psychiatric thinking, as an editorial representing the physicians of this state is appalling.

Dr. Messer's diatribe is most unscientific and mostly unsubstantiated. The case studies he cites are clearly not examples of homosexuality, but of pseudohomosexuality. Furthermore, to state that because a man marries and produces progeny is evidence of a cure is both simplistic and inaccurate.

Many psychiatrists in practice today see older heterosexuals who are lonely and depressed, just as they may see older homosexuals in similar circumstances. Depression and loneliness, far from being the exclusive domain of homosexuals, is the leading problem encountered by psychiatrists in our society. And there are many heterosexual couples freely choosing not to procreate who would resent the implication that their choice leaves them feeling deprived and somehow unfulfilled.

If indeed there is a renewed interest in current thinking on homosexuality as this editorial would imply, perhaps there is a need for an appropriate scientific exchange which might shed new light on the subject — something which Dr. Messer's contribution decidedly does not.

Sincerely,
S. I. Ostrow, M.D., General Practitioner,
Non MAG Member
President, Georgia Association of Physicians for Human Rights
Box 14652,
Atlanta 30324

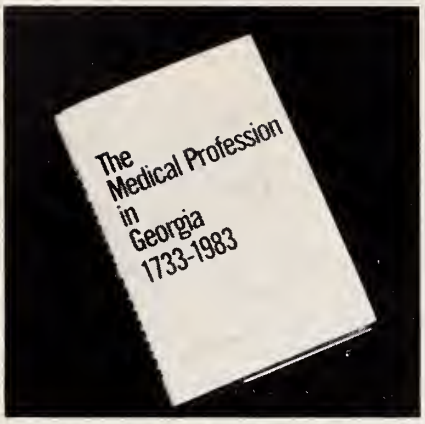
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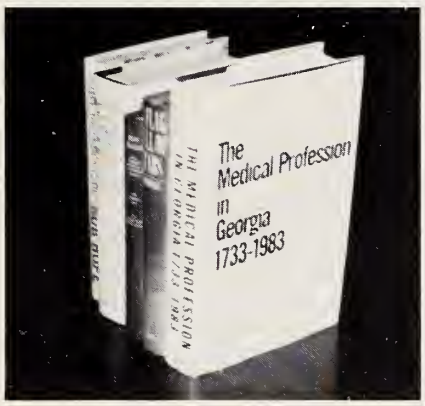
Dear Sir:

Thanks to the efforts of you . . . and Evelyn Gay, the Auxiliary issue of the *MAG Journal* [February, 1983] received a national award at the recent AMAA convention in Chicago. A new category was added to the award list to include it. I am very pleased and wanted . . . you to know how happy I am.

Sincerely,
Barbara Thibodeaux (Mrs. David C.)
Immediate Past President
Auxiliary to the MAG
June 27, 1983

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1-4—*Montego Bay, Jamaica:* **The Sixth Annual Pediatric Postgraduate Course.** Sponsored by the Scottish Rite Children's Hospital. Category 1 and AAFP prescribed credits. Contact Judson L. Hawk, Jr., M.D., Dir. of Ped. Ed., Scottish Rite Hosp., 1001 Johnson Ferry Rd., Atlanta 30363. PH:404/256-5252.

9-14—*Atlanta:* **American Academy of Orthopaedic Surgeons 51st Annual Meeting.** Contact AAOS, 444 N. Michigan Ave., 15th Floor, Chicago, IL 60611. PH:312/822-0970.

10-12—*Atlanta:* **Georgia Psychiatric Assn. Winter Meeting: "Treatment of Severe Character Disorders."** Category 1 credit. Contact J. Tom Sawyer, 938 Peachtree St., NE, Atlanta 30309. PH:404/876-7535 or 1-800-282-0224 (toll free in Ga.).

18-25—*Park City, Utah:* **2nd Annual Winter Urology Seminar.** Category 1 credit. Contact Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., NE, Atlanta 30322. PH:404/329-5695.

20-25—*Augusta:* **19th Annual Family Practice Symposium.** AMA Category 1 and AAFP prescribed credit. Contact Div. of Cont. Ed., MCG, Augusta 30912. PH:404/828-3967.

24—*Atlanta:* **Clinical Problems in Neurology.** Category 1 credit. Contact Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., NE, Atlanta 30322. PH:404/329-5695.

27-Mar. 2—*Paradise Island, Nassau, Bahamas:* **Problems of Chronic Pain.** Category 1 credit. Contact Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., NE, Atlanta 30322. PH:404/329-5695.

MARCH

2—*Atlanta:* **Nutrition in the Later Years.** Contact Ann Robinson, Coll. of Health Sciences, Box 873, Ga. State Univ., Atlanta 30303. PH:404/658-3085.

4-10—*Keystone, CO:* **Snow Job in OB/GYN.** Category 1 credit. Contact Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., NE, Atlanta 30322. PH:404/329-5695.

6-9—*Durango, CO:* **Seventh Annual Symposium on Emergency Medicine.** Category 1 and AAFP prescribed credit. Contact Div. of Cont. Ed., MCG, Augusta 30912. PH:404/828-3967.

14-16—*Atlanta:* **American Society for Clinical Pharmacology and Therapeutics.** Contact ASCPT, 1718 Gallagher Rd., Norristown, PA 19401. PH:215/825-3838.

MARCH

23-24—**Risk Management Seminar.** Category 1 credit. Contact Ms. CaRita Connor, Georgia Medical Society, P. O. Box 5716, Savannah 31404. PH:912/355-6607.

APRIL

2-3—*Atlanta:* **Nutrition, Eating, and Behavior.** Contact Ann Robinson, Coll. of Health Sciences, Box 873, Ga. State Univ., Atlanta 30303. PH:404/658-3085.

4-6—*Atlanta:* **Techniques in Orthopaedic Surgery.** Category 1 credit. Contact Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., NE, Atlanta 30322. PH:404/329-5695.

5-7—*Atlanta:* **Introduction Into Percutaneous Transluminal Angioplasty III.** Category 1 credit. Contact Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., NE, Atlanta 30322. PH:404/329-5695.

6-7—*Callaway Gardens:* **4th Annual Geriatric Conference for Primary Physicians.** Category 1 credit. Contact Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., NE, Atlanta 30322. PH:404/329-5695.

8-12—*Atlanta:* **American Association of Neurological Surgeons.** Contact AANS, 625 N. Michigan Ave., Ste. 1519, Chicago, IL 60611. PH:213/944-4205.

9-12—*Atlanta:* **Demonstrations in Percutaneous Transluminal Angioplasty XI.** Category 1 credit. Contact Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., NE, Atlanta 30322. PH:404/329-5695.

12-14—*Atlanta:* **Pharmacology for the Anesthesiologist.** Category 1 credit. Contact Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., NE, Atlanta 30322. PH:404/329-5695.

14-15—*Atlanta:* **The Cardiac Patient: Management for Cardiopulmonary Bypass.** Category 1 credit. Contact Dir., Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., NE, Atlanta 30322. PH:404/329-5696.

16-18—*Atlanta:* **Pediatric Infectious Diseases and Immunology.** Category 1 credit. Contact Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., NE, Atlanta 30322. PH:404/329-5695.

26-29—*Atlanta:* **MAG's 130th Annual Session.** Contact J. Tom Sawyer, MAG, 938 Peachtree St., NE, Atlanta 30309. PH:404/876-7535 or 1-800-282-0224 (toll free in Ga.).

26-29—*Atlanta:* **American College of Physicians.** Contact ACP, 4200 Pine St., Philadelphia, PA 19104. PH:215/243-1200.

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COURSE ANNOUNCEMENT

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CONTRAINDICATIONS: Known hypersensitivity reaction to PROCARDIA.

WARNINGS: Excessive Hypotension: Although in most patients, the hypotensive effect of PROCARDIA is modest and well tolerated, occasional patients have had excessive and poorly tolerated hypotension. These responses have usually occurred during initial titration or at the time of subsequent upward dosage adjustment, and may be more likely in patients on concomitant beta blockers.

Severe hypotension and or increased fluid volume requirements have been reported in patients receiving PROCARDIA together with a beta blocking agent who underwent coronary artery bypass surgery using high dose fentanyl anesthesia. The interaction with high dose fentanyl appears to be due to the combination of PROCARDIA and a beta blocker, but the possibility that it may occur with PROCARDIA alone, with low doses of fentanyl, in other surgical procedures, or with other narcotic analgesics cannot be ruled out. In PROCARDIA treated patients where surgery using high dose fentanyl anesthesia is contemplated, the physician should be aware of these potential problems and, if the patient's condition permits, sufficient time (at least 36 hours) should be allowed for PROCARDIA to be washed out of the body prior to surgery.

Increased Angina: Occasional patients have developed well documented increased frequency, duration or severity of angina on starting PROCARDIA or at the time of dosage increases. The mechanism of this response is not established but could result from decreased coronary perfusion associated with decreased diastolic pressure with increased heart rate, or from increased demand resulting from increased heart rate alone.

Beta Blocker Withdrawal: Patients recently withdrawn from beta blockers may develop a withdrawal syndrome with increased angina, probably related to increased sensitivity to catecholamines. Initiation of PROCARDIA treatment will not prevent this occurrence and might be expected to exacerbate it by provoking reflex catecholamine release. There have been occasional reports of increased angina in a setting of beta blocker withdrawal and PROCARDIA initiation. It is important to taper beta blockers if possible, rather than stopping them abruptly before beginning PROCARDIA.

Congestive Heart Failure: Rarely, patients, usually receiving a beta blocker, have developed heart failure after beginning PROCARDIA. Patients with tight aortic stenosis may be at greater risk for such an event.

PRECAUTIONS: General: Hypotension: Because PROCARDIA decreases peripheral vascular resistance, careful monitoring of blood pressure during the initial administration and titration of PROCARDIA is suggested. Close observation is especially recommended for patients already taking medications that are known to lower blood pressure. (See Warnings.)

Peripheral edema: Mild to moderate peripheral edema, typically associated with arterial vasodilation and not due to left ventricular dysfunction, occurs in about one in ten patients treated with PROCARDIA. This edema occurs primarily in the lower extremities and usually responds to diuretic therapy. With patients whose angina is complicated by congestive heart failure, care should be taken to differentiate this peripheral edema from the effects of increasing left ventricular dysfunction.

Drug Interactions: Beta-adrenergic blocking agents: (See Indications and Warnings.) Experience in over 1400 patients in a non-comparative clinical trial has shown that concomitant administration of PROCARDIA and beta-blocking agents is usually well tolerated, but there have been occasional literature reports suggesting that the combination may increase the likelihood of congestive heart failure, severe hypotension or exacerbation of angina.

Long-acting nitrates: PROCARDIA may be safely co-administered with nitrates, but there have been no controlled studies to evaluate the antianginal effectiveness of this combination.

Digitalis: Administration of PROCARDIA with digoxin increased digoxin levels in nine of twelve normal volunteers. The average increase was 45%. Another investigator found no increase in digoxin levels in thirteen patients with coronary artery disease. In an uncontrolled study of over two hundred patients with congestive heart failure during which digoxin blood levels were not measured, digitalis toxicity was not observed. Since there have been isolated reports of patients with elevated digoxin levels, it is recommended that digoxin levels be monitored when initiating, adjusting, and discontinuing PROCARDIA to avoid possible over- or under-digitalization.

Carcinogenesis, mutagenesis, impairment of fertility: When given to rats prior to mating, nifedipine caused reduced fertility at a dose approximately 30 times the maximum recommended human dose.

Pregnancy: Category C. Please see full prescribing information with reference to teratogenicity in rats, embryotoxicity in rats, mice and rabbits, and abnormalities in monkeys.

ADVERSE REACTIONS: The most common adverse events include dizziness or light-headedness, peripheral edema, nausea, weakness, headache and flushing each occurring in about 10% of patients, transient hypotension in about 5%, palpitation in about 2% and syncope in about 0.5%. Syncopal episodes did not recur with reduction in the dose of PROCARDIA or concomitant antianginal medication. Additionally, the following have been reported: muscle cramps, nervousness, dyspnea, nasal and chest congestion, diarrhea, constipation, inflammation, joint stiffness, shakiness, sleep disturbances, blurred vision, difficulties in balance, dermatitis, pruritus, urticaria, fever, sweating, chills, and sexual difficulties. Very rarely, introduction of PROCARDIA therapy was associated with an increase in anginal pain, possibly due to associated hypotension.

In addition, more serious adverse events were observed, not readily distinguishable from the natural history of the disease in these patients. It remains possible, however, that some or many of these events were drug related. Myocardial infarction occurred in about 4% of patients and congestive heart failure or pulmonary edema in about 2%. Ventricular arrhythmias or conduction disturbances each occurred in fewer than 0.5% of patients.

Laboratory Tests: Rare, mild to moderate, transient elevations of enzymes such as alkaline phosphatase, CPK, LDH, SGOT, and SGPT have been noted, and a single incident of significantly elevated transaminases and alkaline phosphatase was seen in a patient with a history of gall bladder disease after about eleven months of nifedipine therapy. The relationship to PROCARDIA therapy is uncertain. These laboratory abnormalities have rarely been associated with clinical symptoms. Cholestasis, possibly due to PROCARDIA therapy, has been reported twice in the extensive world literature.

HOW SUPPLIED: Each orange, soft gelatin PROCARDIA CAPSULE contains 10 mg of nifedipine. PROCARDIA CAPSULES are supplied in bottles of 100 (NDC 0069-2600-66), 300 (NDC 0069-2600-72), and unit dose (10x10) (NDC 0069-2600-41). The capsules should be protected from light and moisture and stored at controlled room temperature 59° to 77°F (15° to 25°C) in the manufacturer's original container.

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Quotes from an unsolicited letter received by Pfizer from an angina patient. While this patient's experience is representative of many unsolicited comments received, not all patients will respond to Procardia nor will they all respond to the same degree.

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J-4044 January 1984

JOURNAL
of the medical association of
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Freestanding Emergency Centers in Georgia — A Comprehensive Look

SELWYN T. HARTLEY, M.D., *Riverdale, and* GOULD B. HAGLER, JR., *Atlanta**

THEY ARE LOCATED in shopping centers and on busy suburban thoroughfares. They have such names as "Southside Emergency Center" and "Cobb Urgent Care Center." Staffed by emergency physicians or family practitioners, they stay open 12 hours a day, 7 days a week. No appointment is necessary. They treat respiratory infections, cuts and scrapes, breaks and strains, sore throats and earaches. Most provide medical care for minor emergencies and episodic illnesses; others offer continuing primary care as well. All advertise — through direct mail, newspapers, radio, and even television.

What are they? They are freestanding emergency centers (FECs). Finding a niche in the health care system between the hospital emergency department and the private physician's office, FECs have become the fastest growing segment of the health care industry. Ten years ago, there were two FECs in the United States. Five years ago, 50. Today FECs number 1,000. Georgia is home to 40, 30 of which are in metropolitan Atlanta. As some view it, FECs are the free market's answer to gaps and inefficiencies in the health care system. To others, FECs are sinister mutants posing dangers to physicians, hospitals, and patients.

About one-fifth of the FECs in the United States are members of the National Association of Freestanding Emergency Centers (NAFEC). Headquartered in Dallas, Texas, NAFEC promotes FECs as a convenient health care alternative — more accessible than a physician's office, less expensive than a hospital emergency room. According to James Roberts, Managing Director of NAFEC, the industry's rapid expansion is "best explained by a consumer demand for lower-cost, more accessible health care." Mr. Roberts believes that the public has now found relief for its "pent up frustration" over the high cost of care and the inconvenient hours of private physicians' offices.

FECs have become one of the fastest growing segments of the health care industry. This article takes a close look at who runs them, who uses them and why, and what services they provide.

Other observers believe that FECs have not met an existing demand so much as they have *induced* demand through heavy advertising. Similarly, these observers do not think FECs are filling an unmet need, but are instead taking patients away from providers who are already giving high quality care. "I feel that freestanding emergency centers are in direct competition with the private practitioners and the hospital emergency rooms," said one Georgia internist. "I feel that they will *not* serve the patient as well as the individual practitioners (in the case of a routine office visit), and not as well as the hospitals (in the case of a more complex emergency)."

Whether they are plowing new ground or carving up territory already claimed by others, FECs are very definitely growing. The Orkand Corporation projects in its recent study of the industry that FECs

* Dr. Hartley is an emergency physician practicing in Clayton County. He was a co-founder of the Toco Hills Emergency Center, the first freestanding emergency center in Georgia. (The Toco Hills Emergency Center was bought by Humana and is now a MedFirst facility.) Mr. Hagler is the Assistant Director of Legislative Affairs at the Medical Association of Georgia.

will number 2,500 by 1985, 3,300 by 1987, and 4,500 in 1990. Today the heaviest concentrations are in Florida, Texas, California, and Tennessee. The reasons for the phenomenal growth are usually described in demographic terms. America's population is highly mobile, and 25 to 35% of Americans in metropolitan areas have no family doctor. There are more single parents and families in which both parents work outside the home: it is often inconvenient for these families to see a doctor during his or her regular office hours.

"The public has now found relief for its 'pentup frustration' over the high cost of care and the inconvenient hours of private physicians' offices."

Increasingly, these families have sought routine medical care in hospital emergency departments. Emergency department visits totalled 81,000,000 in 1981, double the 1960 figure. Eighty percent of these visits do not involve life-or limb-threatening conditions. Seventy percent could be treated in a physician's office.

Peter Bossack, M.D., founder of the East Cobb Medical and Emergency Center, said, "I thought I could do a better job than the hospital. After working in [hospital emergency departments] for 2½ years, I got very discouraged at the long wait, the impersonality, and the expense. You can treat 80% of the people who come to emergency rooms — whose lives are not threatened — in a better atmosphere in a freestanding emergency center."

Jon Prieksat, MedFirst's Regional Manager for Atlanta, cited similar reasons for his company's entry into the field. "One of the trends we recognized was the problem of overutilization of hospital emergency rooms for non-emergency medical needs."

MedFirst centers are operated by Humana, Inc. However, Mr. Prieksat and other MedFirst officials state quickly and repeatedly that MedFirst centers are not FECs. "We are actually engaged in providing primary care," said Jean Cardin, M.D., Medical Director of MedFirst's Norcross center. "Each physician actually holds his or her practice in this given location with the intent of developing a family practice. Fortunately, we have a lot of equipment in these offices, so we can do certain things for our patients like suturing of wounds and caring for certain orthopedic injuries, minor injuries. But we don't intend that this is the primary purpose of our offices."

In Georgia, as in other states, freestanding emergency centers are almost exclusively a suburban phenomenon. The MedFirst Centers and the FECs proper are clustered in the suburban counties surrounding Atlanta — Cobb, DeKalb, Gwinnett, Clayton, and in North and South Fulton. They have also spring up — but are much less numerous — in Muscogee, Bibb, Richmond, Glynn, and Dougherty counties. One is also planned for Savannah. Twelve of Georgia's centers are MedFirsts. Three are owned by Ambulatory Resources, Inc., a subsidiary of Charter Medical. The remainder are independently owned, often founded by emergency room physicians such as Dr. Bossack.

Persons in the industry cite *availability* as the major service offered by freestanding emergency centers and as the main reason for their overwhelming success. Patients who awaken with a sore throat in the morning can go to an FEC before work or on their lunch hour and be treated without making prior arrangements. The man who cuts his hand while mowing the lawn after work can go to the center and have his laceration repaired. If x-rays and laboratory work are necessary, they can be performed there.

Patients seen at FECs and hospital emergency departments complain that doctors' offices require appointments (which may or may not be kept by the doctor) and/or require an expensive complete history and physical examination including routine laboratory and x-rays on the first visit. Patients desiring only episodic care are unwilling to meet those office requirements.

The equipment and capabilities of FECs vary, but in general they have more than a private physician's office and less than a hospital emergency department.*

Most freestanding emergency centers do not have a respirator, blood bank, arterial blood gas capability, or rapid access to operating rooms which limit the FEC physicians' resources in managing trauma victims. This is not considered a problem, though, because major trauma victims are transported by ambulance, and the ambulances are prohibited from taking victims to any facility except a hospital emergency department unless directed to do otherwise by the patient. Naturally, FECs do not want to receive major trauma victims because of their limited capabilities and the long delay for other patients when the trauma victim monopolizes the facility's resources.

Staffing generally consists of a physician, nurse, receptionist, and lab/x-ray technician. Ray Fowler, M.D., at the Douglasville Emergency Center, uses EMTs instead of nurses, and has found this to be a satisfactory staffing arrangement. All of the medical

* Typical FECs are equipped with oxygen, suction, EKG, cardiac monitor, defibrillator, x-ray, and a laboratory that can do a CBC, urinalysis, blood sugar, amylase, Gram Stain, throat culture, urine culture, and pregnancy test. They usually have a contract with a radiologist who reads all x-rays, and use nearby hospitals for STAT laboratory tests or reference labs for routine tests. Some centers, however, can perform cardiac enzyme, electrolyte, and blood gas determinations on site. A few also have radio communications with local ambulances and actively participate as a part of the EMS system.

personnel are trained in CPR and some in Advanced Cardiac Life Support. Typically, the physician and nurse have had experience working in a hospital emergency department and the physician's training will have been family practice, internal medicine, or surgery. Until recently almost all the physicians have been young, at the beginning of their professional careers, but with increasing numbers of primary care physicians competing for patients more and more established physicians are closing their practices and taking jobs in freestanding emergency centers.

According to NAFEC's Jim Roberts, a typical patient of an FEC is "a person between the ages of 25 and 40, who lives in a suburban area; his income profile would be in the $25,000 range." NAFEC has studied this patient's medical conditions as well as his demographic characteristics. When asked to list medical conditions considered among the five most frequently seen, 75% of the survey respondents listed upper and lower respiratory infections among the top five. Fractures and sprains and lacerations and suturing were tied for second, 66%. Ear, nose and throat conditions were listed by 50% of the respondents. Urinary tract infections were named as being in the top five by one-sixth of the respondents, as were major medical related problems (uremia, cardiopulmonary, hypertension/hypotension, chest pains).

"You can treat 80% of the people who come to emergency rooms — whose lives are not threatened — in a better atmosphere in a freestanding emergency center."

The price of FECs' services tend to confirm their general description as hybrids between a doctor's office and a hospital emergency department. "Our charges are about 50 to 60% of hospital charges for treating a patient with a similar problem," according to Cathleen Tuley, M.D., Medical Director of MedFirst's College Park center. A typical FEC charge for a new patient brief visit (CPT 90000) is $25 to $30, compared to the typical hospital charge of $40. Charges for ancillary services (laboratory, x-ray, suture trays, crutches, splints, etc.) are much less expensive at the FEC. Comparisons made by NAFEC, the Orkand Corporation, the Robert Wood Johnson Foundation, and private FEC owners have verified these claims and have shown that centers operated by hospitals are more expensive for patients than privately owned centers.

Frederick Cowen, M.D., Medical Director of MedFirst's Atlanta centers, points out that hospitals have greater operating expenses because of staffing patterns, facilities, and equipment to care for a small number of seriously ill or injured patients. Some hospitals also treat large numbers of charity patients, and the paying patients must bear that cost unless the county reimburses the hospital for indigent care.

It is difficult to compare FEC charges with physician's office charges, but FEC owners report that they try to make their charges about 10% higher than doctor's offices, reflecting the "convenience store" attitude of charging more for availability.

Ten years ago, there were two FECs in the United States. Five years ago, 50. Today FECs number 1,000.

Quality of care varies from center to center as do facilities and cost. The credentialing process for physicians at some centers is quite severe (including an Equifax Profile on the physician) but at most centers the investigation of the physician-employee is less stringent than that required by hospitals. Those centers that are owned by the physician have no review process for that physician and are like any physician's office in that regard. FEC owners recognize that theirs is a service industry and patient complaints about personnel, including physicians, are taken seriously; owners consider public relations as well as scientific skills an important qualification for the physician.

Many FECs are owned by non-physicians, who are unqualified to evaluate these issues. For that reason, some centers have formed quality assurance programs. The freestanding emergency center physician, though, does not undergo the close scrutiny of the hospital emergency department physician who refers all his patients to another physician for followup. The quality of the FEC physician review, like other aspects of FECs, is somewhere between the hospital physician review and the doctor's office physician review.

Quality of care varies not only from center to center but also from physician to physician within specific centers. This variation also occurs in hospital emergency departments and doctors' offices. Physicians working in freestanding emergency centers feel they provide better care than traditional doctors' offices, but physicians who have a traditional office practice feel they provide better care than the centers. Added to this disagreement over the quality of care is the controversy over whether episodic care is adequate medical care.

Concern over this issue of quality of care has prompted in Georgia and elsewhere legislation to regulate FECs at the state level. "We had heard of freestanding emergency centers being built in other states, and thought we should be ready in case significant numbers were built in Georgia — ready with a

regulatory mechanism to protect the public." That, according to Rusty Kidd, MAG's director of legislative affairs, was the genesis of H.B. 1553. This 1982 law included "freestanding emergency care clinics" as institutions to be licensed by the Department of Human Resources.

The issue of state licensure of FECs has spurred debate in Georgia and elsewhere. Is regulation necessary to ensure quality of care, or is it just one more unwarranted governmental intrusion in private professional affairs?

NAFEC maintains that FECs are private physicians' offices in which specialists in emergency medicine practice their profession. NAFEC opposes state licensure of these physicians' offices. "NAFEC totally opposes regulatory efforts based on constitutional issues as well as pragmatics," said Jim Roberts in *Emergence*, NAFEC's monthly newsletter. Roberts adds, "Regulation is only an attempt to thwart competition and to deprive consumers of the opportunity to make private decisions about when, where, and how to seek medical care."

Dr. Bossack (East Cobb Medical and Emergency Center), on the other hand, does see some need for state regulation. "Because of the money-making potential of these places, you're going to have people opening them up who aren't necessarily qualified. There should be some sort of protection to the public to keep those operations from opening." But Dr. Bossack does not "feel comfortable" with DHR's proposed regulations. "There is too much red tape and not enough focus on quality of care." Dr. Bossack is skeptical of the state's ability to accomplish quality of care through regulation and would prefer some kind of professional self-regulation, perhaps through a Georgia association of FECs.

Persons in the industry cite availability as the major service offered by FECs and as the main reason for their overwhelming success.

The Georgia Hospital Association (GHA) has adopted no policy on the issue of licensure; however, a spokesman for GHA said that, in his estimation, "the bulk of hospitals are in favor of regulating freestanding clinics. Without regulation it might be possible for some facilities to be developed that are substandard."

Although the legislative authority for regulation originated at MAG, the Association has recently taken a position against licensure of FECs. William D. Logan, Jr., M.D., MAG's Secretary, was a member of the *ad hoc* committee which developed MAG's position. Dr. Logan gave two reasons for MAG's present stance: "First, we are generally opposed to government regulation and red tape unless there is some overriding necessity, and we see no overriding necessity in this case. Second, we thought that licensing of private doctors' offices would be a dangerous precedent."

MAG does, however, oppose the use of the term "emergency" by any facility not open 24 hours a day and not equipped to treat life- and limb-threatening conditions. "In short," said Dr. Logan, "these places could continue to do what they're doing, without regulations, but they should have to change their name. We think the use of the word emergency is misleading and potentially dangerous."

"Because of the money-making potential of these places, you're going to have people opening them up who aren't necessarily qualified. There should be some sort of protection to the public to keep those operations from opening."

FECs are a new form of medical care delivery, and their appearance has been met with varying degrees of apprehension, skepticism, and even hostility. MedFirst's Dr. Cardin said that her facility was perceived as "quite a threat when we initially moved in." The patients were literally instructed by their pediatricians and family practitioners "Do not go to MedFirst." Dr. Bossack reported a similar reception when he first opened in Cobb County. "The family physicians in particular really thought we were out to take their patients away." Both stated that this hostile attitude has mellowed over time. Dr. Bossack attributed this change to two factors: the high quality of care which he provides and the fact that he does not offer continuing care, but instead refers all his patients back to their family physicians. Dr. Cardin said that she frequently sees other physicians' patients on weekends and when they are on vacation. In such cases, Dr. Cardin sends the records back to the patient's regular doctor.

"Concern" is the word most frequently heard when one questions physicians in traditional private practice about FECs. "We have concerns about these centers and how they're operated. We're concerned about the adequacy of care and the continuity of care provided in freestanding centers," said Charles D. Hollis, Jr., M.D., in reference to the freestanding facilities in Albany.

The Bibb County Medical Society reacted with some concern to the establishment of two FECs in Macon, according to Jack F. Menendez, M.D. "One of our concerns is that persons with serious emergencies might go to freestanding facilities and

delay treatment, and another concern is that they're now branching out into continuing care.''

Hank Holderfield, Executive Director of the DeKalb County Medical Society, noted, ''Many of our members have concerns about the quality of medical care being delivered in freestanding facilities. We have received complaints about the quality of care. Most have not been placed in writing, and we have not been able to verify them, but they do cause us concern. The number one concern expressed by DeKalb county physicians about convenience clinics is that Humana and MedFirst in their advertising and promotions are presenting themselves as a substitute for your family physician. I don't think they can deliver on this promise.''

''NAFEC totally opposes regulatory efforts based on constitutional issues as well as pragmatics.''

Hospitals are also watching FECs, but they do not generally display as much concern as physicians. ''We have noticed little or no impact in terms of our patient load in our emergency room,'' said Bernie Brown, administrator at Cobb County's Kennestone Hospital. John Carpenter of Savannah's Candler Hospital views FECs in a positive light. He said that he believes that FECs are treating patients who have before inappropriately sought treatment in emergency rooms. ''Our emergency rooms are geared for really traumatic sorts of situations and the cost for a patient in a hospital emergency room covers those kinds of staffing and equipping.'' Mr. Carpenter has a dim view of a person with a minor illness subsidizing the operation of an emergency room. ''I believe in getting what you pay for and paying for what you get,'' he said.

Sister Mary Faith, R.S.M., President of St. Joseph's in Savannah, disagrees with Mr. Carpenter. She said that ''the freestanding center presupposes in a lot of cases that the patient is able to make a diagnosis, and there are many cases where that is a dangerous presupposition.'' She added that ''the patient who goes to a freestanding center is giving up the benefit that going to a doctor's office would give him of the doctor's knowing his history and the benefit of going to an emergency room which would give him an immediate backup in case his condition were a true emergency.''

Debates between FEC physicians and medical organizations will continue for years, but freestanding emergency centers are an undeniable success in the medical marketplace. The success of freestanding emergency centers is an extension of the emergency medicine phenomenon. Emergency medicine was the first specialty to arise from patient demand rather than scientific advancement. Emergency medicine responded to the demand for readily available episodic care. The freestanding emergency center extends that availability from the hospital to the community and reduces the waiting time by avoiding monopolizing problems such as major trauma. In all likelihood, the FEC industry will continue to prosper for several reasons.

1. There is a great push from governmental agencies and insurance companies toward out-patient medicine, and these centers are designed as out-patient facilities.
2. Initially freestanding emergency centers had to advertise to educate the public about their services. These centers have developed marketing expertise which has proved successful.
3. Freestanding emergency centers are the ''convenience stores'' of medicine and their increased availability is attractive to the public.
4. A large number of patients desire only episodic care and not a close relationship with their doctors.

Debates between FEC physicians and medical organizations will continue for years, but freestanding emergency centers are an undeniable success in the medical marketplace.

Freestanding emergency centers have had a definite effect on traditional medical practices in Georgia. Physicians have responded by keeping their offices open for evening and weekend hours and eliminating some of their requirements for the first visit. Some physicians have converted their traditional offices to freestanding emergency centers. The medical marketplace is changing rapidly and growing more competitive. As more primary care physicians enter practice, the competition for patients will continue. Freestanding emergency centers are merely the first result of this competition which in its various forms will have a great impact on the private practice of medicine.

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The most unusual aspect of this case is the fact that it was sporadic and acquired outside of the usual endemic area.

Endemic Histoplasmosis in a Georgia Resident

GLENN L. GOODHART, M.D., *Atlanta**

Introduction

Histoplasmosis is mostly found in a well defined endemic area in the United States, presumably because of conditions affecting the soil, the natural reservoir of the fungus. In the endemic area, which includes the Missouri, Ohio, and Mississippi River Valleys, histoplasmosis occurs both sporadically and in epidemics. Wherever histoplasmosis occurs, it is generally either a self-limited or asymptomatic disease, although occasional chronic cavitary or chronic disseminated cases occur. I have recently encountered a life-long Georgia resident who experienced chronic cavitary histoplasmosis. The rarity of active cases of histoplasmosis in Georgia and the South generally prompts this report.

Case Report

The patient was a 61-year-old white man who had lived in Griffin, Georgia, his entire life. In approximately October, 1982, he began to experience hoarseness. He was treated with antibiotics but did not improve. Laryngoscopy was performed, and several abnormal-looking areas were biopsied on 3/10/83. Routine histologic sections suggested the diagnosis of histoplasmosis. Fluorescent antibody studies of the pathologic specimens (performed by the Fluorescent Antibody Laboratory, Centers for Disease Control, Atlanta, Georgia) subsequently confirmed the presence of *Histoplasma capsulatum* in the tissues, and sputum cultures grew the fungus.

The patient had a 23-year history of cluster headaches. He was refractory to most drugs. When I first saw him April, 1983, he was consuming as many as 100 Tylenol # 3 tablets per week as well as 900 mg. of lithium carbonate per day. Approximately 3 years ago, he had been placed on 30 mg. of prednisone daily for the headaches. The dosage had been reduced to 20 mg. a day in the 6 months before admission. Extensive questioning to elicit a history of exposure to bat guano or bird roosts was negative. Chest x-ray showed infiltrates in both apices with cavitation on the right. Multiple sputum cultures for AFB were negative. However, the *H. capsulatum* serum complement fixation titres against histoplasma mycelial phase antigens were $> 1:256$ and against yeast 1 : 16. Blood and urine fungal cultures were negative for *H. capsulatum*.

The patient received a total dose of intravenous amphotericin B of 1,061 mg. The first 541 mg. were given in the hospital, and the remainder as an outpatient, thrice weekly. His hospitalization was complicated by azotemia, lithium toxicity, and codeine withdrawal syndrome. In addition, his prednisone dosage was first converted to an alternate day regimen and then tapered without effect on his headache frequency.

Subsequent to the course of amphotericin B, the patient was placed on ketoconazole 400 mg/day. He has remained on ketoconazone for 4 months without consequence. His hoarseness is gone, and the chest x-ray is stable. A county health department officer inspected his home and work place looking for possible environmental sources of histoplasmosis. No bird roosts or bat guano was found; no soil samples were taken.

Discussion

This patient was unusual in several respects. Histoplasmosis involving the oropharynx or laryngeal areas is frequently a manifestation of disseminated

* Dr. Goodhart specializes in the treatment of infectious diseases. Send reprint requests to him at 960 Johnson Ferry Rd., NW, Ste 243, Atlanta, GA 30342.

histoplasmosis.[1] Bennet's report describes 53 patients with orolaryngeal histoplasmosis culled from the literature, at least 29 of whom had disseminated disease. Blood and urine cultures were negative in the present case, however. Furthermore, this patient's laryngeal histoplasmosis seemed to be the result of innoculation from cavitary pulmonary histoplasmosis and thus is reminiscent of the pathogenesis of laryngeal tuberculosis.[2]

Although histoplasmosis is seen in otherwise healthy people, it is also a well known disease of the immunosuppressed; this patient was taking steroids consistently. Because failures of ketoconizole therapy of histoplasmosis have more frequently been seen in the immunosuppressed,[3] I initially treated him with amphotericin, tapered the steroids, and only then started ketoconazole.

Histoplasmosis is a well known disease of the immunosuppressed.

However, the most unusual aspect of this case is the fact that it was a sporadic case acquired outside of the usual endemic area. Recent reports of histoplasmosis in the South have been of outbreaks resulting from massive exposures of small populations.[4, 5] The present case differs in that no microfocus was identified but rather an immunosuppressed patient apparently contracted disease from low-grade endemic exposure.

Endemic exposure to histoplasmosis has been studied nationwide and has been found to be minimal in Georgia. In a comprehensive study of military recruits conducted between 1958 and 1968,[6] Edwards et al. estimated that they had actually skin tested 1 in 15 of all white men in the United States age 17 by the time they had reached age 22. They reported data on about 250,000 men who had lived life-long in single counties. The authors were thus able to map out geographic zones of low and high prevalence. In the authors' own words, in the South, a low prevalence area, even the low reactivity rates to histoplasmin were ''. . . undoubtedly inflated by cross reactions.'' Nationally, the frequency of reactivity was 20%. Reactivity rates in metropolitan areas of Georgia were 4.6% and in the non-metropolitan areas were 9.0%. In the patient's county of residence, Spaulding, the results of 631 patients were reported, and only 20 had reactions of more than 10mm(3.2%). In contrast, 59.4% reacted to PPD-B and 1.9% to PPD-S. These rates of histoplasmin reactivity are much lower than in the heart of the endemic zone. The highest reactivity rates were seen in Kentucky: 71.8% in the metropolitan areas.

Because histoplasmosis is not a reportable disease, no actual case-rate data are available for histoplasmosis in Georgia. However, the Georgia State Laboratory received only 390 requests for serologic tests for fungal diseases between January, 1981, and May, 1983 (personal communication, Thomas McKinley, Georgia Department of Human Resources). No information was available about seroconversions or positive cultures. By comparison, about 10 times as many cases of syphilis — often considered a ''rare'' disease — were actually confirmed in Georgia over the same time frame.

Thus, based on the prevalence of histoplasmin reactivity and requests for fungal serologic tests, confirmed cases of histoplasmosis in Georgia must be a rarity. In the present case, the diagnosis was well confirmed by biopsy findings, serologic titres, culture results, and response to therapy. Physicians practicing in the South should consider the diagnosis of histoplasmosis, particularly in immunosuppressed patients.

Summary

A Georgia resident developed chronic cavitary histoplasmosis with laryngeal involvement. The patient was chronically immunosuppressed with steroids. He was initially treated with amphotericin B and tapering of the steroids followed by ketoconizole. This immunosuppressed patient apparently contracted disease from low-grade endemic exposure.

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These study results suggest that P^{32} is a safe, well tolerated, and effective adjuvant therapy to surgery in patients with ovarian malignancy.

Intraperitoneal Radioactive Chromic Phosphate (P^{32}) in the Treatment of Ovarian Cancer

JOHN L. POWELL, M.D., *Athens,* and ARTHUR B. KIRCHNER, M.D., *Atlanta**

Abstract

The use of intraperitoneal radioisotopes in the management of women with ovarian cancer is controversial. We studied the use of an intraperitoneal colloidal suspension of chromic phosphate (P^{32}) in 22 patients with varying stages and grades of ovarian malignancy. Nine patients received adjunctive chemotherapy, and two received external radiotherapy. Morbidity related to P^{32} was minimal, with small bowel obstruction occurring in only one patient who had also received external pelvic irradiation. After a median follow-up time of 20 months (range, 5-45 months), 18 patients (81%) are free of disease; four patients died, three of recurrent ovarian carcinoma and one of bladder carcinoma. These results suggest that P^{32} is a safe, well tolerated, inexpensive, and effective adjuvant therapy to surgery in the management of patients with ovarian malignancy.

THE INTRAPERITONEAL INJECTION of radiocolloids was introduced in the management of cancer of the ovary 38 years ago. The rationale for this method was to prevent seeding of cancer cells following complete surgical removal of the tumor, particularly when there had been rupture and spillage of the tumor during surgery. The two most commonly used radiocolloids were phosphorus-32 (P^{32}) given as chromic phosphate ($CrPO_4$) and colloidal gold-198 (Au^{198}). Most of the information available about this form of therapy has been gained from the administration of colloidal gold. This work was pioneered in 1945 by Muller in Zurich, Switzerland.[1] He first used radioactive zinc but changed to radioactive gold when it became available in 1949. Muller calculated that 150 mCi of Au^{198} introduced into the peritoneal cavity delivers 4,000 rads to the peritoneal serosa, 6,000 rads to the omentum, and 7,000 rads to the retroperitoneal lymph nodes. Several studies[2-6] have strongly suggested that the use of adjuvant intraperitoneal radioactive colloidal gold following surgical removal of all gross disease in Stage I carcinoma of the ovary has enhanced the 5-year survival rate but has also produced significant morbidity — including fistulas, peritonitis, and in particular, intestinal obstruction, in 10-11% of cases.[2, 4]

Colloidal radioactive chromic phospate (suspended in two percent pectin and 30 percent glycogen) was used postoperatively in ovarian cancer for the first time in 1955 at Memorial Hospital by Henschke.[7] Subsequent studies[8-12] indicate that the use of P^{32} is safe and is associated with a high survival rate when used as an adjuvant therapy for early cancer of the ovary. In these recent studies, P^{32} was chosen over Au^{198} because of the significant complication rate resulting from the use of intraperitoneal Au^{198}. These complications, not commonly seen with P^{32}, are believed to be due to the differences in characteristics of the two substances. P^{32} is a pure beta irradiation emitter, whereas Au^{198}, in

* Dr. Powell is a gynecologic oncologist, and Dr. Kirchner is a radiation therapist. Send reprint requests to Dr. Powell at 740 Prince Ave., Athens, GA 30601.

addition to emitting beta irradiation, also emits gamma rays. The shorter half-life of Au^{198} compared to P^{32} (2.7 days versus 14.5 days, respectively) results in irradiation of the tissues at a higher rate, which may result in a higher complication rate. Additionally, P^{32} was preferred over Au^{198} because: (1) its higher beta energy results in greater tissue penetration (0.69 versus 0.32 meV); (2) its longer half-life makes it easier to order and use compared to the shorter half-life of Au^{198} which requires almost immediate use, and; (3) its pure beta particle emissions are not harmful to hospital personnel, so patient isolation is not required. The gamma rays from Au^{198} are harmful to exposed individuals, and isolation of the patient for approximately 1 week is required. The patient treated with P^{32} frequently can be managed as an outpatient or can be discharged the following day. Because of the higher energy and the longer half-life of P^{32} compared to Au^{198}, 15 mCi of P^{32} is considered equivalent to 150 mCi of Au^{198}.

Materials and Methods

From October, 1979, to February, 1983, 22 consecutive patients with invasive ovarian carcinoma meeting the following criteria received intraperitoneal P^{32} postoperatively: 1) histopathologic review of the ovarian tumor had to demonstrate an invasive carcinoma; 2) there could be no evidence of macroscopic residual ovarian cancer after surgery, and; 3) there could be no adhesions in the pelvis or upper abdomen that would inhibit the dispersion of P^{32} throughout the entire peritoneal cavity. Homogenous distribution of a tracer isotope (technetium-99m) had to be documented before instillation of P^{32}. No patient was treated with P^{32} in whom gross residual tumor was found following surgery.

The median age of the 22 patients was 56 years (range, 30-71 years). Eight patients had serous cystadenocarcinoma; three, mucinous cystadenocarcinoma; one, clear cell adenocarcinoma; seven, endometroid adenocarcinoma; and three, granulosa cell carcinoma. Tumor grades were Grade 1, nine patients; Grade 2, 10 patients; and Grade 3, three patients. The cases were all classified according to the International Federation of Gynecology and Obstetrics staging system (Table 1). Four patients had Stage IA disease; one, Stage IB; three, Stage IC; two, Stage IIA; one, Stage IIB; five, Stage IIC; five, Stage III; and one, Stage IV. Eight patients had been referred for treatment with a history of intraoperative rupture and spillage of a cystic tumor. Six patients were treated because peritoneal washings had been cytologically positive for malignant cells. One patient was treated for ascites containing malignant cells. Five patients were treated with P^{32} following a positive second-look procedure in which only minute foci of microscopic tumor were detected after a year of combination chemotherapy. Two patients were treated following a positive third-look procedure in which only minute foci of microscopic tumor were detected after two prior courses of combination chemotherapy; one patient had received 18 months and the other 30 months of chemotherapy.

TABLE I — FIGO Staging System for Carcinoma of the Ovary

Stage I	**Growth limited to the ovaries.**	
	Stage IA: Growth limited to the ovary; no ascites.	
	1. No tumor on the external surface; capsule intact.	
	2. Tumor present on the external surface, or capsule(s) ruptured, or both.	
	Stage IB: Growth limited to both ovaries; no ascites.	
	1. No tumor on the external surface; capsule intact.	
	2. Tumor present on the external surface, or capsule(s) ruptured, or both.	
	Stage IC: Tumor either stage IA or IB, but with ascites* present or with positive peritoneal washings.	
State II	**Growth involving one or both ovaries with pelvic extension.**	
	Stage IIA:	**Extension and/or metastases to the uterus and/or tubes.**
	Stage IIB:	**Extension to other pelvic tissues.**
	Stage IIC:	**Tumor either stage IIA or stage IIB, but with ascites* present or with positive peritoneal washings.**
Stage III	**Growth involving one or both ovaries, with intraperitoneal metastases outside the pelvis, or positive retroperitoneal nodes, or both. Tumor limited to the true pelvis with histologically proven malignant extension to small bowel or omentum.**	
Stage IV	**Growth involving one or both ovaries with distant metastases. If pleural effusion is present, there must be positive cytology to allot a case to stage IV. Parenchymal liver metastasis equals stage IV.**	
Special Category	**Unexplored cases that are thought to be ovarian carcinoma.**	

***Ascites is peritoneal effusion that, in the opinion of the surgeon, is pathologic, or clearly exceeds normal amounts, or both.**

Ten patients received, following surgery, intraperitoneal P^{32} as their only mode of adjunctive therapy, and 12 received other adjunctive therapy in addition to intraperitoneal P^{32} (nine, chemotherapy; and three, external pelvic irradiation). Six women received a mean of six courses of melphalan (range, 3-12 courses), and three women received combination regimens (two were given 10 courses of cyclophosphamide, doxorubicin, and Cis-platinum, and one received eight courses of hexamethylmelamine, cyclophosphamide, and Cis-platinum). There was no difference in stage of disease between patients who received just P^{32} and those who also received other adjunctive therapy. Patients who received chemotherapy or radiation in addition to P^{32} tended to have a higher grade of tumor (2 of the 9 patients with Grade I, 7 of the 10 patients with Grade II, and all 3 of the patients with Grade III). All seven patients with endometrioid cancer received chemotherapy or external radiation. All patients with initial Stage III or IV disease received P^{32} when positive

second- or third-look procedures revealed microscopic residual tumor after prior combination chemotherapy.

Approximately 15 mCi of P^{32} was given between 1 and 6 weeks postoperatively when the patient was eating a regular diet and there were no signs of ileus or infection. The P^{32} deteriorates at approximately 10 percent per day. The dosage is calculated at its point of origin (Mallinckrodt Nuclear, St. Louis, Missouri 63134), and the amount the patient received was an approximation, depending upon the percent of deterioration due to transportation or delay in instillation due to postoperative difficulties.

Using sterile technique, two 16 gauge polyethylene catheters are threaded through No. 14 gauge needles under local anesthesia into the peritoneal cavity. Insertion sites are selected about 2½ inches from the midline on both sides of the abdomen. The catheters are flushed with 10 cc of normal saline to insure patency. A tracer dose of four mCi technetium-99m pertechnetate sulfur colloid suspension diluted in 100 cc of normal saline is injected into the peritoneal cavity via the catheters (half the volume and dose via each catheter). The patient is positioned from supine to sitting and to both lateral decubeti and then placed under a gamma camera. After homogenous distribution of the tracer isotope is documented by scanning the peritoneal cavity, a dose of 15 mCi of colloidal radioactive chromic phosphate suspended in 30% dextrose with 2% benzyl alcohol was introduced as a bolus using an additional 100 cc normal saline (half of the volume and dose via each catheter). The polyethylene catheters were removed and bandaids applied. Since P^{32} is a pure beta emitter, latex gloves afforded sufficient protection to involved personnel. All material contaminated by the radioactive isotopes was retained in the Department of Radiation Oncology and stored until decay.

As opposed to being treated with Au^{198}, the patient treated with P^{32} frequently can be managed as an outpatient or can be discharged the following day.

During the next 2 hours the patient was repositioned at 15 minute intervals to maximize contact with the entire peritoneal surface. P^{32} emits a beta particle with a maximum range of 3.8 mm, and colloidal radioactive chromic phosphate forms a physical bond with the peritoneal and serosal surfaces. Hence, no patient required isolation, no special attention was given to the disposal of body wastes, and no patient remained hospitalized to wait for decay of the isotope.

TABLE II — Survival by Cell Type, Stage and Grade of Ovarian Tumor

Cell Type	*Alive*	*Dead*	*Total*
Serous cystadenocarcinoma	6	2*	8
Mucinous cystadenocarcinoma	2	1	3
Clear cell adenocarcinoma	1	0	1
Endometroid adenocarcinoma	6	1	7
Granulosa cell carcinoma	3	0	3
Stage			
I	7	1	8
II	6	2*	8
III	4	1	5
IV	1	0	1
Grade			
I	8	1	9
II	9	1*	10
III	1	2	3

*Single patients who died of uremia without ovarian cancer

Results

Eighteen of the 22 patients are living and without clinical evidence of malignancy a median of 20 months following administration of P^{32} (range, 5-45 months; 6 for $<$ 12 months). Four patients died, three of ovarian cancer and one of uremia secondary to carcinoma of the bladder. At postmortem examination 26 months following treatment with P^{32}, the latter patient had no evidence of ovarian cancer. An additional patient (initially Stage IIB, grade 1) recurred extraperitoneally 6 months after treatment with P^{32} alone. She currently has no evidence of disease following laparotomy with excision of tumor from the recto-vaginal septum and 10 courses of combination chemotherapy; she has been off all therapy for 6 months. Thus, to date, 19 patients (86%) have clinically had complete intraperitoneal responses. No patient has been lost to follow up.

The patients who died had varying cell types, stages, and grades of tumor (Table 2). Three patients (initially Stage IC, Grade 1; Stage IIC, Grade 3; Stage III, Grade 3) died of ovarian cancer a mean of 28 months following instillation of P^{32}. One patient had progressive disease, refused further therapy, and died 16 months following P^{32} alone. The second received melphalan chemotherapy for 12 months following P^{32}, was found to have residual tumor at a second-look procedure 18 months after P^{32}, and subsequently died 33 months post-P^{32} despite additional combination chemotherapy. The third patient received P^{32} and additional combination chemotherapy after a second-look procedure revealed persistent tumor microscopically; clinical recurrence of tumor occurred 34 months after P^{32}, and she died 2 months later.

To date, no significant difference in survival or intraperitoneal recurrence of disease has been noted between the patients treated with P^{32} alone compared to those also treated with chemotherapy or

TABLE III — Therapy and Survival by Cell Type, Stage, and Grade of Tumor

Cell Type	P^{32} Alone*	P^{32} and chemo- or Radiotherapy*
Serous cystadenocarcinoma	4	4(2†)
Mucinous cystadenocarcinoma	2(1)	1
Clear cell adenocarcinoma	1	0
Endometroid adenocarcinoma	0	7(1)
Granulosa cell carcinoma	3	0
Stage		
I	5(1)	3
II	2	6(2†)
III	3	2(1)
IV	0	1
Grade		
I	7(1)	2
II	3	7(1†)
III	0	3(2)

*Number of patients (number of deaths)
†Single patient who died of uremia without ovarian cancer

external irradiation (Table 3). Two of the twelve patients who received chemotherapy or external irradiation along with P^{32} have had intraperitoneal recurrence and died of ovarian cancer; the remaining patients are clinically free of disease. One of the ten patients treated with P^{32} alone has had intraperitoneal persistence of tumor and died (as noted above), and a second patient had the appearance of extraperitoneal disease (as noted above), but not intraperitoneal disease, and is alive and clinically well.

Four of the five patients with second-look procedures after initial failure of surgery plus chemotherapy are living at a mean of 17 months of followup. Two patients with positive third-look procedures are living after follow up periods of 8 and 20 months.

There were no acute complications that could be attributed to P^{32} instillation. Only one patient sustained a major late complication — intestinal obstruction secondary to irradiation injury 20 months following P^{32} instillation plus 4,500 rads external pelvic irradiation. She required a by-pass procedure at which time there was no evidence of ovarian carcinoma.

Discussion

It is clear from this study that the use of intraperitoneal P^{32} in the manner described is safe and simple to administer. An additional advantage is the absence of severe side effects and late sequelae which are associated with the use of either total abdominal irradiation or long-term chemotherapy. Abdominopelvic external irradiation is poorly tolerated and is not an effective salvage treatment in patients with limited or microscopic residual tumor following initial combination chemotherapy.[13] Total abdominopelvic irradiation following extensive combination chemotherapy often produces unacceptable

TABLE IV — Cost to Patient for Receiving P^{32}

Item	Cost
P^{32}, 15 mCi	$475.00
Technetium, 4 mCi	16.50
Supplies (sterile gloves, towels, needles, syringes, lidocaine, saline, alcohol wipes, gauze, tape, and photograph of scan to document distribution)	37.42
Outpatient facility	39.20
Physician fee	150.00
Total	$718.12

myelosuppression and gastrointestinal toxicity and is therefore often not feasible. Furthermore, the significant deleterious effects from extended chemotherapy over 2 years include the development of leukemia and aplastic marrow changes.

In addition, the cost of intraperitoneal P^{32} is relatively inexpensive when compared to the cost of chemotherapy or external pelvic irradiation. The expenses incurred by a patient receiving intraperitoneal P^{32} at our institution amount to $718.12 (Table 4). This cost is comparable to the expense of 1 month of combination chemotherapy and one-half the cost of 1 month of external pelvic irradiation.

To date, no significant difference in survival or intraperitoneal recurrence of disease has been noted between the patients treated with P^{32} alone compared to those also treated with chemotherapy or external radiation.

While we cannot compare our survival data with those reported by other workers, particularly because of the short duration of follow up, the survival rates are both similar and encouraging. Keettel et al[3] administered 150 mCi of radiogold to 53 women who had undergone total abdominal hysterectomy and bilateral salpingo-oophorectomy (TAHBSO) for Stage I-IIA carcinoma of the ovary and obtained an 83% 5-year survival rate. Decker et al[4] subjected 46 women with Stage I carcinoma of the ovary who had undergone TAHBSO to intraperitoneal injection of 140 mCi of colloidal radiogold and reported 73.2% survival at 5 years. Hester and White[8] administered 7-42 mCi of P^{32} in fractionated doses to 33 patients for Stage I-IV carcinoma of the ovary with only 15 survivors with no evidence of tumor. Hilaris and Clark[9] instilled a mean dose of 15 mCi P^{32} in 26 women with Stage I carcinoma of the ovary after TAHBSO; pelvic irradiation was added in one-third of the cases. The determinate 5-year survival rate was 92%. Alderman et al[10] added 10-17 mCi P^{32} following TAHBSO and omentectomy in 21 patients with Stage I carcinoma of the ovary. They reported one death secondary to recurrent ovarian carcinoma

and one death from cerebrovascular occlusion in a patient who was free of disease at the time of death. Their range of follow up was 1-52 months. Piver et al[11] delivered a mean dose of 15 mCi P^{32} to 20 patients with Stage I carcinoma of the ovary, most of whom had undergone TAHBSO, and reported a survival of 19 (95%) without evidence of recurrent ovarian cancer during a follow up of 1½-6 years. One patient died of carcinoma of the colon at 5.6 years with no evidence of residual ovarian cancer at autopsy. One patient died of recurrent ovarian cancer at 4.5 years. Julian et al[12] treated 40 patients with Stage I-IV cancer of the ovary with 15 mCi of P^{32}. Nineteen were treated with external radiation in addition. Their overall survival in Stage I disease was 83%, Stage II 69%, Stage III 17%, and no 3-year survivors for Stage IV.

Radioactive chromic phosphate appears to be of theoretical and practical value in patients with ovarian malignancies that are removed completely, in patients with malignant cells spilled into the abdominal cavity at operation from a ruptured cyst, and in an occasional patient with minute seedlings of metastatic disease less than 3 or 4 mm in greatest measurement in the pelvis or abdomen. Although it is stated[3, 14] that spillage of tumor cells into the abdominal cavity apparently carries no greater risk to the patient, we feel that this is a patient that may benefit most from intra-abdominal radioisotope therapy. Decker et al[15] in 1973 reported an 80% 5-year survival rate in 25 patients with ruptured Stage I ovarian cancer using radioactive gold compared to a 43% 5-year survival rate in 22 patients with Stage I ovarian cancer in whom the cyst ruptured during operation but in whom radioactive gold was not given. For reasons stated previously, we prefer radioactive chromic phosphate to radioactive gold.

There should be no adhesions in the pelvis or upper abdomen that would inhibit the dispersion of P^{32} throughout the entire peritoneal cavity.

Some years ago we stopped using the technique of placing indwelling catheters at the time of surgery because we felt that: 1) catheter blockage and loculation occurred fairly often; 2) the incidence of ileus was greater; and 3) the chance for contamination from leakage of P^{32} from the sites of prolonged catheter insertion was significant.

According to American Cancer Society statistics,[16] there will be approximately 11,500 deaths from ovarian cancer in this country in the year 1983. In this same year, there will be about 18,200 new cases reported. The overall cure rate for this disease is currently a depressing 20-30%. Ovarian cancer is now the most common cause of death from gynecologic malignancy, in spite of the fact that it is second in order of frequency of occurrence among gynecologic malignancies. In the United States, a woman dies of ovarian cancer every 50 minutes, and the majority of these are within 1 or 2 years from diagnosis. Ovarian carcinoma is such a treacherous malignancy that every means at our disposal should be utilized in its treatment.

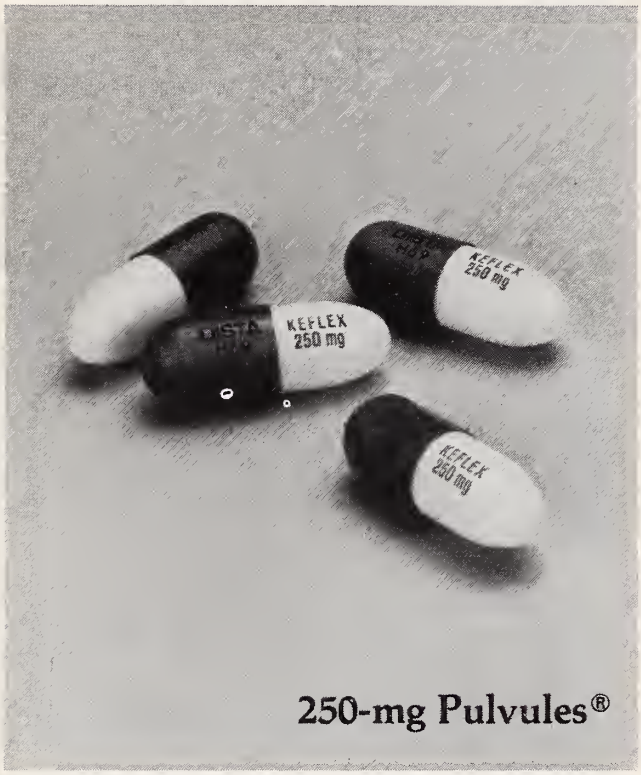
There were no acute complications that could be attributed to P^{32} instillation.

Radioisotopes in colloidal suspensions have been used to suppress malignant pleural and peritoneal effusions due to ovarian cancer since their introduction by Muller in 1945.[1, 17] There is little doubt that this procedure has palliative value for many ovarian cancer patients with recurrent ascites or pleural effusion. We feel that the adjunctive use of postoperative intraperitoneal radioactive chromic phosphate enhances survival and is most beneficial to the patient whose disease is clinically confined to the ovaries, the patient in whom a malignant cyst is ruptured during operation, and possibly the patient with peritoneal seeding less than three or four mm in diameter.

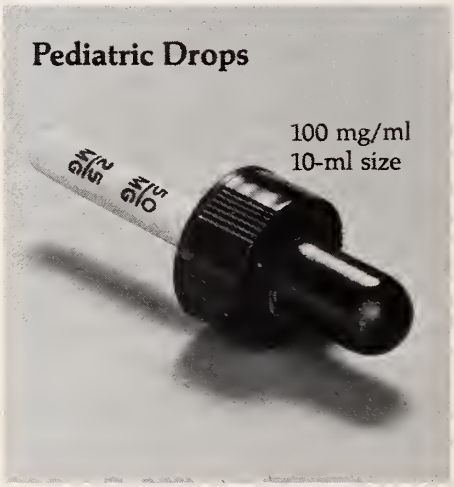
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This method of treatment may obviate the need for disfiguring surgery.

Intramasseteric Hemangioma: Nonoperative Treatment with Transarterial Embolization with Microparticles

IRA F. BRAUN, M.D., and FOAD NAHAI, M.D., *Atlanta**

Abstract

Intramuscular hemangiomata are uncommon lesions in the head and neck. Surgical therapy may require radical removal of vital muscular structures which would interfere with function such as mastication and, in addition, be grossly disfiguring. We present a case of an intramasseteric hemangioma treated solely with transarterial embolization with microparticles, thereby obviating the need for disfiguring surgery.

Introduction

INTRAMUSCULAR HEMANGIOMATA are uncommon lesions, particularly in the head and neck region.[1] In a large review series of 1308 patients with hemangiomata, only 0.8 percent were confined to skeletal muscle.[2] Most occur in muscles of the extremities, with the greatest incidence found in the quadriceps muscle.[3] This incidence is presumably related to the volume of muscle mass located in different body areas.[1] In a comprehensive review of 393 patients with intramuscular hemangiomata studied up to 1957, Scott[3] found a 13.5 percent incidence in the head and neck, with most occurring in the trapezius and masseter muscles.

* Dr. Braun is from the Department of Radiology, Section of Neuroradiology, and Dr. Nahai is from the Department of Plastic and Reconstructive Surgery, Emory University School of Medicine, in Atlanta. Send reprint requests to Dr. Braun, Department of Radiology, Section of Neuroradiology, Emory University School of Medicine, 1364 Clifton Rd., NE, Atlanta, GA 30322.

Surgical therapy for extensive intramuscular hemangiomata may be difficult. The optimum surgical goal in order to prevent recurrence is complete excision with ligation of all feeding vessels. Excessive intraoperative blood loss is an obvious complication of surgery of these highly vascular neoplasms. Surgery can also be disfiguring, can interfere with normal muscular function, can potentially injure vital nervous structures and, indeed, may not be indicated if the lesion is situated in vital muscular structures such as the tongue.

We wish to report a case of an intramasseteric hemangioma which we believe falls into the inoperable category. The patient was successfully treated non-surgically with microembolization following subselective catheterization of afferent feeding arterial pedicles. The purpose of this communication is to briefly review the pertinent literature, describe the technique of microembolization, and establish its role in the treatment of these unusual lesions.

Case Report

The patient is an 18-year-old man whose parents first noted right sided facial swelling when he was 6 years old. No significant change in the swelling was noted until several months prior to admission when a gradual increase in the size of the mass was noticed by the patient and his parents. The patient experienced occasional dull pain since the increased swelling. There was no history of trauma, dental abnormalities, infection, impairment of vision, salivation,

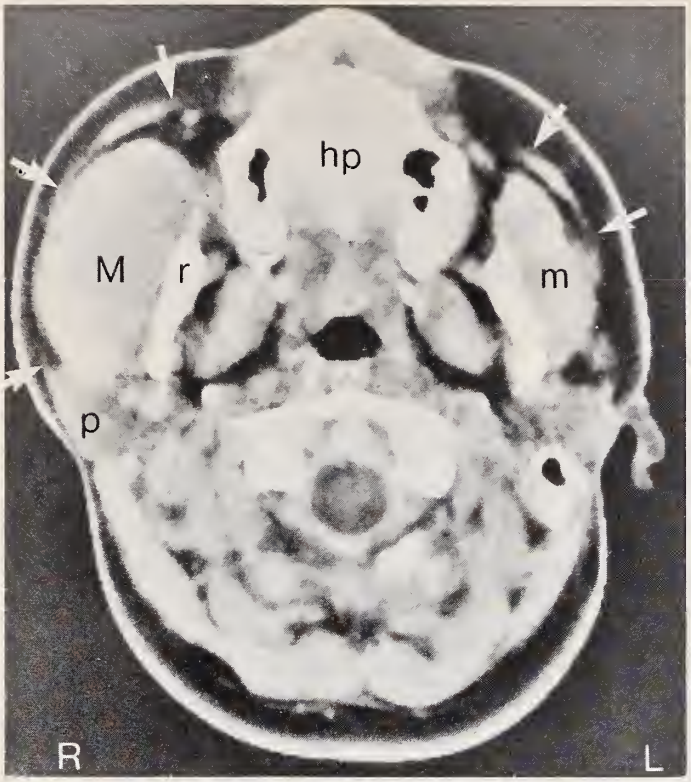


Figure 1a — Transaxial CT slice through the hard palate (hp). An enlarged masseter muscle (M) is noted on the right just lateral to and abutting on the ramus (r) of the mandible. This is compared to the normal masseter muscle (m) on the left. The enlarged right masseter is homogeneous in texture with preservation of normal fascial planes. Posterior displacement of the anterior aspect of the parotid gland (p) is noted on the right. No invasion or involvement of the parotid gland is evident. Stensen's duct is seen bilaterally (large arrows). The CT scan confirms that the mass, whose precise location was not evident clinically, is entirely extraparotid and intramasseteric.

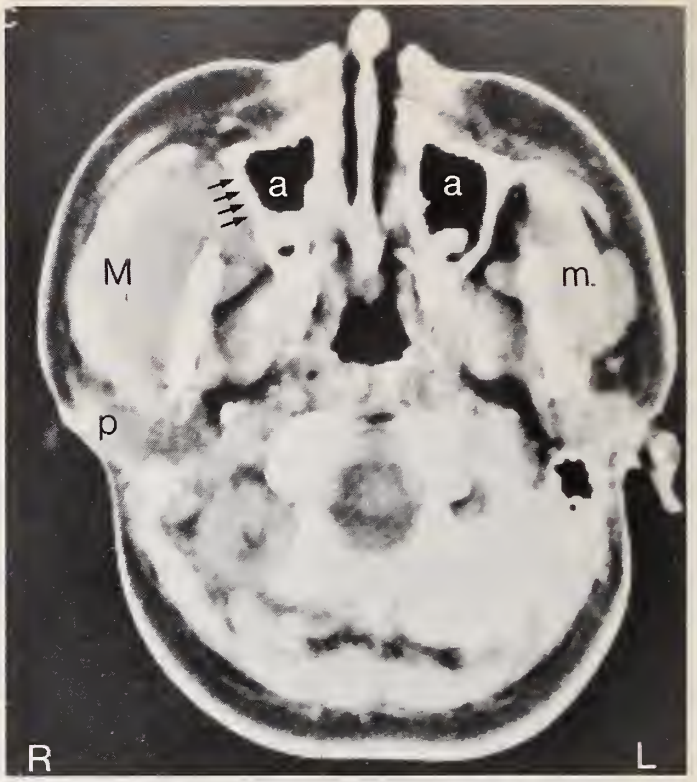


Figure 1b — Transaxial contiguous CT slice taken through the floor of the maxillary antra (a) bilaterally. A slight bony deformity of the posterolateral aspect of the right maxillary antrum is evident (small arrows), secondary to pressure effects attesting to the chronicity of the intramasseteric mass lesion. Compare the appearance of the right maxillary antrum to its counterpart.

numbness, or apparent involvement of facial nerve function.

Physical examination revealed an obvious, nontender, soft, non-compressible mass, with indistinct boundaries measuring approximately 8 x 10 cm in the buccal parotid region of the right face. No bruits or thrills were noted.

All laboratory test results were within normal limits.

Hospital Course

A computed tomographic (CT) examination of the face was obtained which revealed the mass to involve the entire masseter and a small portion of the inferior aspect of the temporalis muscle (Figure 1). The parotid gland itself was uninvolved. The mass was fairly discrete without encroachment on the surrounding fat planes.

Subsequent common carotid and subselective external carotid angiography were performed which revealed that the major supply to this mass was via branches of the transverse facial artery (Figures 2 and 3a). Minimal additional supply was noted from the mid deep temporal artery.

With the patient under neurolept anesthesia, the transverse facial supply to this mass was embolized using microparticles of polyvinyl alcohol foam (Ivalon). Post embolization angiography (Figure 3b) revealed no evidence of significant tumor vascularity with preservation of the normal arterial trunks. The patient tolerated the procedure well and was discharged neurologically intact.

The patient was seen 1 month and interviewed 6 months following embolization. A marked decrease in the size of the facial swelling was readily apparent in the 1 month visit. In addition, the patient reported a decrease in the intensity of the previously noted buccal pain. The patient will undergo repeat angiography with the possibility of a second stage embolization procedure of the mid deep temporal supply in the near future.

Discussion

Intramuscular hemangiomata, first described by Liston[4] in the semimembranous muscle, are distinctly uncommon in the head and neck region. Most occur in the muscles of the extremities presumably related to the volume of muscle mass.[1] In review of 393 cases reported until 1957, Scott[3] described 28 in the head and 15 in the region of the neck. Sixty percent of these lesions occurred in the trapezius and masseter muscles, with 19 cases involving the masseter exclusively.



Figure 2a — Lateral view of a magnified subtracted image of the right common carotid arteriogram. A highly vascular blush is evident on the lateral view of this common carotid study (arrows). Without using subselective techniques, the precise afferent feeding vessels are obviously impossible to identify.



Figure 2b — Anteroposterior view of the right common carotid arteriogram using subtraction technique. A highly vascular blush is appreciated in the right masseteric region (arrows). The intracranial portion of the internal carotid artery (ica) is evident.

The lesions are considered to be probably congenital in origin since 93% of Scott's series of 393 cases were discovered in patients prior to their 30th year. While previous trauma has been reported as a possible inciting event in the natural history of this neoplasm,[1] only 17% of reported cases have a history of trauma to the region of the tumor.

Pathologically, on gross inspection, normal muscle fibers are separated by firm tumor tissue and vascular spaces of varying sizes.[3] Proliferating epithelial cells are noted microscopically between striated muscle fibers. Well formed capillaries and small veins may be present in some places while small endothelial lined vascular spaces may be seen elsewhere. Muscle fibers lose their striations and degenerate until they disappear completely toward the center of the lesion. Although the lesions are not malignant and do not metastasize, they will spread by contiguity and infiltrate surrounding tissue rendering local surgery impractical.[3]

These lesions are rarely diagnosed preoperatively.[5] They most commonly present as a localized swelling which is rarely compressible.[1] The mass is usually rubbery in consistency with pulsations, thrills, and bruits almost always absent.[1, 3] Dilated vessels giving the overlying skin a bluish coloration have been reported. Pain is a presenting complaint in over one-half the patients and is thought to be due to direct compression of neighboring tissue by the enlarging mass. Pain may at times be very severe and disabling.[3] Loss of function of the involved muscle may also occur with resulting physical deformity.

The appearance of phleboliths has been reported as a radiologic finding in some cases.[3] The computed tomographic characteristics of this lesion has not to our knowledge been reported prior to this communication. Angiography has been reported to reveal the vascular nature of this lesion,[3, 5] although no images could be found in the literature.

Surgical therapy has been used on most of the reported cases in the literature. Conley and Clairmont[1] consider the best treatment in usual cases to be complete excision with ligation of all major feeding



Figure 3a — Lateral magnified view of a superselective arteriogram of the proximal trunk of the transverse facial artery, the main arterial afferent supply to this lesion, using subtraction technique. The body of the catheter (curved arrows) is situated in the external carotid artery. The tip of the catheter is within the proximal trunk of the transverse facial artery (T). Diffuse neoplastic, irregular vascularity is appreciated within the depths of the hemangioma (H). Puddling of contrast material is seen in fine neoplastic vasculature in the distribution of the masseter muscle.



Figure 3b — Post embolization arteriogram. Lateral magnified subtracted view of the transverse facial artery is obtained after micro-embolization using polyvinyl alcohol foam particles. Minimal, if any, neoplastic vessels are now evident. There is complete preservation of the normal trunks of the transverse facial artery.

blood vessels. They do warn that minor arterial feeders, not angiographically visible, may be encountered and lead to excessive blood loss during surgery. Lesion recurrence may be related to incomplete excision of these minor feeders. Incomplete removal, in addition, will lead to later recurrences and deeper invasion making subsequent excision impossible.[3, 5]

Extensive surgery, however, may be contraindicated when a vital muscle such as the entire tongue is involved or, as in our patient, when disfiguring removal of the masseter muscle, the major muscle of mastication, is required. Radiation, sclerosing agents, and electrocoagulation may result in cessation of pain and a decrease in tumor size, but the effect is considered only temporary.[3]

The intra-arterial treatment of vascular lesions has been shown to be effective using subselective catheterization techniques.[6] The development and use of small embolic "microparticles"[7] coupled with the detailed knowledge of the "functional" anatomy of the vascular system of the head and neck, has also refined these methods.[8]

Embolization using microparticles of embolic agent, a technique not previously emphasized, prevents blood vessels in the vicinity from providing collateral supply to the lesion, such as can be seen in proximal ligation of afferent arterial pedicles, proximal embolization with large particles, or incomplete surgical removal. The injected microparticles lodge within the depths and interstices of the vascular neoplasm, where collateralization cannot occur and produce irreversible tissue necrosis.[9]

While embolization as a preoperative adjunct or perhaps as the only form of therapy for these lesions has been suggested,[6] this is the only report to our knowledge of successful endovascular treatment of an intramuscular hemangioma. We feel that these lesions should be embolized with microparticles as the initial step in their treatment. Some patients will then be rendered more favorable surgical candidates by decreasing the vascularity of the lesion while in some, perhaps in most, embolization will be the only therapy needed.

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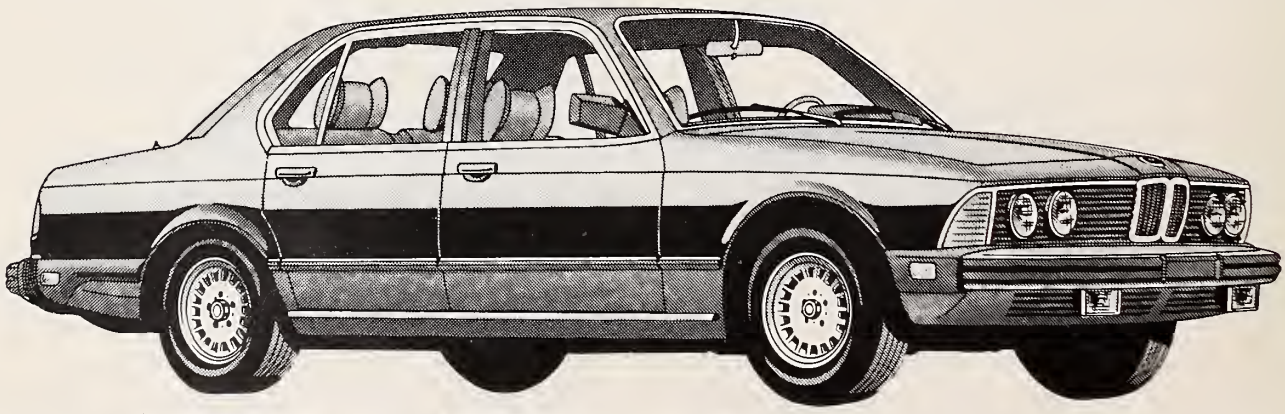
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A Critical Legislative Issue: Delegation of Tasks Within a Physician's Office

Is it proper, is it legal for you, a licensed medical doctor, to control the quality of care in your office by delegating to your employees those duties you want them to perform?

For years, the customary practice of all physicians has been to assume total responsibility and liability for the acts of their employees. In so doing, the physician delegates to the employee certain tasks, according to the physician's directive, to take an x-ray, obtain a blood sample, do an EKG, measure blood pressure, obtain a medical history, give a shot, etc.

Most of these employees are not specifically licensed by the State to perform such tasks, but are doing so as the agent of the M.D., under his direct supervision, his direct order, and his liability.

IS THIS LEGAL?

The attorneys for the MAG say yes. However, there are two contradicting Attorney General rulings, one stating a physician can delegate, the other saying that he cannot.

Which ruling governs your office practice?

Obviously, this question has an impact on the practice of every physician in Georgia. It also has an impact on the overall cost of medical care.

Several groups have and are planning legislation to specifically require that only those persons licensed by the state can perform certain medical functions, such as take an x-ray, draw blood, etc., regardless of any degree of M.D. supervision.

The PIP is the most valuable daily function that you can participate in to have an influence as to the outcome of legislation while the General Assembly is in session.

HOW IT WORKS!

Every morning at 8:30, a minimum of 10 physicians meet with a MAG staff person at the Howard Johnson's Stadium Motel near the Capitol. They are briefed as to what the major issues are and are taken to the Capitol by shuttle bus. The MAG staff person will assist you in contacting *your* State Senator and State Representative so you can let them know how you feel on the issues.

You are encouraged to attend committee meetings to assist MAG's lobbying efforts in presenting testimony and answering questions on medical issues.

THE PIP PROGRAM IS WORTH THE TIME AND EFFORT. NINETY-SIX OF LAST YEAR'S PARTICIPANTS PLAN TO VISIT THE CAPITOL AGAIN IN 1984.

LEGISLATORS WANT YOU TO BE INVOLVED.

THE OUTCOME OF THE INFORMED CONSENT ISSUE DEPENDS ON YOUR INVOLVEMENT.

THE OUTCOME OF TORT REFORM DEPENDS ON YOUR INVOLVEMENT.

THE OUTCOME OF WHETHER YOU CAN DELEGATE DEPENDS ON YOUR INVOLVEMENT.

PIP — PHYSICIAN INVOLVEMENT PROGRAM — IS YOUR PROGRAM TO MAKE THE DIFFERENCE.

The Attorney General has already ruled, for example, that only an M.D. or licensed audiologist can perform a diagnostic hearing test. There is no leeway for the R.N. whom the M.D. has trained for the past 10 years to perform such tests unless she obtains an audiologist's license. This obviously will require the otolaryngologist, the internist, the pediatrician, and the family practitioner to employ a licensed audiologist rather than a licensed R.N.

One can imagine the impact on every physician's office if in fact custom is changed, thus requiring only the M.D. to perform all tests, etc. or to have to employ persons licensed to perform specific functions with no overlap of duties. This would further skyrocket the cost of medical care without improving its quality.

The MAG is seeking clarification of this through the Attorney General's office and will if necessary have legislation introduced in the 1984 Georgia General Assembly which, if passed, will put into law what is currently custom — that a medical doctor can delegate acts to his non-licensed employees under his direct supervision and direct order for which he assumes total responsibility and liability.

If you agree with the MAG position on this issue, you are urged to contact your State Senator and State Representative.

By the time you read this, the legislature will be in session. The most effective way for you to inform the legislature of your opinion on this and other issues is to be a part of the MAG PHYSICIAN INVOLVEMENT PROGRAM (PIP). Call MAG today and sign up.

James A. Kaufmann, M.D., Atlanta
Chairman, MAG Committee on Legislation

Rusty Kidd, Atlanta
Director of MAG's Legislative Activities

The Importance of Preparing Truthful, Accurate, and Complete Medical Records

ROBERT N. BERG, *Atlanta**

RECENTLY, a common theme running through my discussions with physicians has been the fact that the practice of medicine is becoming more and more complicated. Usually, these comments relate to the complications arising out of what might be termed the "legal practice of medicine" — complying with the numerous statutory, regulatory, and case law obligations imposed upon physicians. Based upon recent trends, including increased enforcement of the antitrust laws in the health care area, the new Medicare prospective payment system, the continued increase in the number of malpractice lawsuits and the like, it is unlikely that the complexity of the modern day physician's medical practice will be lessened in the near future.

In the shuffle to comply with the myriad legal obligations placed upon physicians, one area in particular is oftentimes overlooked — the preparation of medical records. The purpose of this month's Legal Page is to indicate some of the reasons why the time spent by physicians in ensuring that medical records are properly, fully, and truthfully prepared is time well-spent. As you will see, medical records can make or break a lawsuit. Improperly prepared or incomplete medical records might help convince a judge or jury as to the physician's liability in a malpractice case. In fact, improper medical records might even serve as an independent basis for finding liability against the physician, or cause the physician to have his or her license to practice suspended or revoked.

The Importance of Truthful Medical Records

It goes without saying that physicians are under a legal and ethical duty to be truthful in preparing medical records. In Georgia, for example, one of the grounds upon which the Composite State Board of Medical Examiners may suspend or revoke a physician's license is if the physician "knowingly made misleading, disceptive, untrue or fraudulent representations in the practice of medicine or in any document connected therewith."[1]

In addition, a physician who falsifies records takes the risk of being liable in a civil action for damages arising out of the physician's actions. For example, in one case,[2] a patient brought an action for damages against a physician, claiming that the physician had falsified records submitted to the patient's insurance company and that, as a result, the patient was denied disability benefits. The Court agreed, holding that:

* Prepared at the request of the Medical Association of Georgia. Mr. Berg is an associate in the firm of Powell, Goldstein, Frazer & Murphy, General Counsel to the Association, 1100 C & S National Bank Building, Atlanta, GA 30335.

the furnishing of false information is actionable if done maliciously or with intention to harm another, or so wrecklessly and without regard to its consequences, that a reasonably prudent person should anticipate that damage to another will naturally follow. . . . It is enough if the falsities charged were intentionally uttered and did in fact cause the [patient] to suffer actual damage in his economic or legal relationships.

In another case,[3] a physician successfully defended against a malpractice action, primarily on the basis of certain medical records prepared by the physician. After the trial, the patient's attorney retained an investigator who discovered that one page of the physician's records was on a form which was not manufactured until 2 years after the date of the earliest of the entries on that page. Based solely upon this fact, the Court ordered a new trial, stating that "the accuracy of the doctor's records [is] a substantive issue and to let the verdict stand might perpetuate a gigantic injustice."

Thus, the first rule for physicians to follow in preparing medical records is a simple one: BE TRUTHFUL!

The Importance of Accurate Medical Records

The proper preparation of medical records, however, involves much more than the simple obligation to be truthful. The likelihood that a physician can successfully defend against a malpractice action may be significantly decreased if the medical records necessary to the physician's defense contain inaccuracies. A recent Connecticut case[4] exemplifies the need for accurate medical records as well as what can happen when inaccurate records are tampered with. In that case, a patient claimed that he was injured while he was in the hospital. In reviewing the hospital's records after the patient's injury, one of the hospital's nurses rewrote an entire section of the patient's medical records, in order to correct certain inadequacies in those records. In dealing with the nurse's actions at trial, the Court held that "(a)n allowable inference from the bungled attempt to cover up the staff inadequacies [in record keeping] was that the revision indicated a consciousness of negligence." Thus, the Court, in its charge to the jury, suggested that the jury could choose to find the hospital negligent on the basis of evidence that the hospital, by knowingly attempting to correct inadequacies in its records, was aware that it had acted negligently.

Another aspect of the importance of keeping accurate medical records is highlighted by a Kansas case[5] in which a maternity patient brought an action against a hospital and one of its nurses for personal injuries sustained as a result of the alleged failure of the nurse to notify the patient's physician that the delivery of the patient's child was imminent. As a result, the child was born unattended by a physician and suffered injuries. During the trial, several physicians testified as expert witnesses that, on the basis of the hospital's records, there was no dereliction of duty on the part of the hospital or its nurse. Unfortunately, those medical records were inaccurate, in that they did not reflect the fact that the nurse alone had delivered the baby. Because of this, the Court allowed the jury to discount the opinions of the expert witnesses. More importantly, the Court expressly instructed the jury that it could find "that if the records were erroneous in one respect, they were erroneous in other respects also."

Thus, the second rule which a physician should follow in preparing medical records: BE ACCURATE!

The Importance of Proper Supervision over the Preparation of Medical Records

The physician's duty goes beyond the actual preparation, truthfully and accurately, of patient medical records. Paraphrasing one Court's description, just as a surgeon is responsible for the negligence of his nurse or surgical attendant employed by him to assist in cutting open and sewing up a patient, a physician also is responsible for derelictions of persons employed by him to carry out the clerical

details which are necessary to the successful performance of the physician's duty to render skillful care and attention to his patient.[6]

A Kentucky case typifies the dangers involved in failing to supervise the preparation and handling of medical records. The patient, suffering pain and numbness in her right arm and wrist, visited an orthopedic surgeon on two occasions. Following the second visit, the physician sent the patient to a second physician for further testing and indicated that the results of the tests should be forwarded to him. The tests were conducted, and the patient attempted on numerous occasions thereafter to learn of the results of the tests. When the first physician repeatedly failed to return the patient's calls, the patient simply "gave up and quit calling the doctor's office." Instead, she went to a third physician who successfully performed the needed operation.

The patient then sued the first physician, claiming that she suffered damages, in the form of the pain and suffering endured by her during the interval between her last appointment with the first physician and the operation. At the trial, it came out that the test results had been delivered to the first physician, but that the results had been misplaced in the physician's files. The physician defended on the grounds that he personally was not negligent, and that any negligence attributed to his office staff could not rise to the level of constituting malpractice. The Court disagreed, however, stating:

> If [the physician] had been an old-fashioned country doctor without any office help and had mislaid his notes on this lady's care and then put her off and forgotten her, there can be little doubt that he could have been held responsible had she died as a consequence of that neglect. Placing a layer of other people, by whomsoever they may be employed, between a physician and his patient does not alter the situation, because the physician's professional duties are not susceptible of being delegated or diffused.

Thus, the third rule which physicians should follow: SUPERVISE THE PREPARATION AND HANDLING OF MEDICAL RECORDS!

The Importance of Complete Medical Records

Finally, there is a question of how much data should be included in a patient's medical record. Generally, the answer to this question is simple — the more data contained in the patient's medical record, the better.

There are several reasons for this general rule-of-thumb. First, a physician's medical records may be the only records available documenting critical information necessary for a successful malpractice defense; oftentimes, records showing a patient's case history, height, weight, and blood pressure can assist in establishing that the particular diagnosis or treatment involved was proper. Also, medical records may contain valuable information showing appointment changes or cancellations, patient complaints or threats, prescription orders, refills and confirmations, requests for copies of patient records, and other matters which may be helpful in defending a lawsuit.

Second, although the issue to our knowledge has never been decided in Georgia, the failure to keep adequate and complete medical records might cause a physician to have his or her license to practice suspended or revoked. This occurred recently in New York, where a physician was found guilty of engaging in "unprofessional conduct" because he included only sparse information in his patient records. The physician attempted to justify his record-keeping by claiming that his policy was to note "only unusual and exceptional matters" in the patient records; thus, if a patient's record contained nothing about the patient's history, physical exam, abnormalities, or the procedure that was performed, this indicated to the physician that all these matters were "normal." The Court summarily rejected this justification, finding that the physician's record-keeping was patently inadequate. Among other things, the Court noted that the "purpose of [requiring complete record-

keeping] is, at least in part, to provide meaningful medical information to other practitioners should the patient transfer to a new physician or should the treating physician be unavailable for any reason.''[7]

Finally, an imaginative plaintiff's attorney might claim that the failure by a physician to keep complete medical records constitutes malpractice, such that a patient damaged by such failure could obtain restitution. In fact, this theory of liability has been tried, albeit unsuccessfully, in a number of cases in other states.[8]

Thus, the fourth rule which physicians should follow: KEEP COMPLETE MEDICAL RECORDS!

Conclusion

In total, there are a number of important reasons why physicians should not overlook their responsibility to keep truthful, accurate, and complete records, and ensure that others preparing or handling medical records for them also do so. Hopefully, you will never be involved in defending a lawsuit in which your medical records will play a role. In this day and time, however, a more realistic approach is to assume that your medical records may become the focal point of a lawsuit, and take the steps necessary to obtain the maximum benefit from those records. Not only will you make life easier for your attorney, you will make life easier for yourself, as well.

Notes

1. O.C.G.A. §43-34-37(a)(2).
2. *Felis v. Greenberg,* 273 N.Y.S.2d 288 (S.Ct.N.Y. 1966).
3. *Kaplan v. Central Medical Group of Brooklyn,* 419 N.Y.S.2d 750 (S.Ct.App.Div. 1979).
4. *Pisel v. Stanford Hospital,* 41 C.L.J. 43 (1980).
5. *Hiatt v. Groce,* 523 P.2d 320 (S.Ct.Kans. 1974).
6. *Boyd v. Bradenhausen,* 556 S.W.2d 896 (S.Ct.Ky. 1977).
7. *Schwarz v. Board of Regents of University, etc.,* 453 N.Y.S.2d 836 (S.Ct.App.Div. 1982). In Georgia, a physician may lose his license to practice for engaging in ''unprofessional conduct,'' which is defined as including ''any departure from, or failure to conform to, the minimal standards of acceptable and prevailing medical practice.'' O.C.G.A. §43-34-37(a)(7).
8. See, e.g., *Boyd v. City of Wyandotte,* 260 N.W.2d 439 (S.Ct.Mich. 1977).

Nutritional Support in Cancer Patients

DANIEL W. NIXON, M.D., *Atlanta**

One of the mysteries of cancer is its ability to grow despite the host's progressive loss of fat and lean body mass. As a result, the signs and symptoms of starvation frequently accompany advanced malignant disease. This undernutrition ultimately contributes directly or indirectly to death. The prevalence of cachexia in cancer and its obvious adverse effects have led to various nonvolitional feeding attempts. These attempts have not been as successful as initially hoped, in part because of the physical and metabolic effects induced by the tumor. This paper reviews studies at Emory University on the prevalence, significance, mechanisms and management of cancer cachexia.

Prevalence

In a study on the Emory Oncology Ward,[1] 42% of patients with advanced cancer had adipose stores (measured by triceps skinfold measurements) less than 80% of standard, and 19% were below 60% of standard. Serum albumin was subnormal in 31%. Most striking, however, was the observation that 88% of the patients had creatinine/height indices (a measure of lean body mass) below 80% of standard and 53% were below 60% of standard. Thus, the widely held clinical impression that cancer patients are frequently undernourished is true.

Significance

Severe undernutrition is thought to increase morbidity and mortality of cancer by impairing the function of the heart, liver, and kidneys, by delaying wound healing and tissue recovery from radiation and chemotherapy, and by decreasing the function of the immune system. On the other hand, starvation up to a point may play some protective role by slowing the growth rate of cancer.

Fifty-six percent of our patients[1] with creatinine height indices less than 60% of standard died within 70 days of study, compared to only 4% of those with higher values. Similarly, 53% of patients with serum albumin concentration less than 3.5 gm/dl died within 70 days, compared to 18% with higher albumin levels. Of those with adipose stores below 60% of standard, 44% died within 70 days compared to 23% of those with higher measurements. Thus, survival seems adversely affected by undernutrition beyond certain threshold levels; the significance of undernutrition above these levels, certainly as regards any protective effect, remains uncertain. Likewise, the precise mechanisms whereby cancer cachexia contributes to death are unclear. As a result, the adverse effects that must be reversed to prolong survival are not known.

* Dr. Nixon is Professor of Medicine, Emory University Clinic, 1365 Clifton Rd., NE, Atlanta, GA 30322. Send reprint requests to him.

Prepared at the request of the Georgia Division, American Cancer Society. Others wishing to contribute papers to this page are invited to send them to Gray T. Fountain, M.D., 910 North Jefferson, Albany, GA 31708.

Mechanisms

Possible causes of cancer cachexia include: 1) decreased food intake, 2) increased nutrient losses through malabsorption or abnormal host metabolic pathways, 3) preferential uptake of nutrients by tumor at the expense of the host.[2] Our understanding of the exact frequency, relative importance and precise mechanisms of these three broad categories remains rudimentary. Malabsorption was uncommon in our patients unless surgical removal of portions of the GI tract had occurred.[1] We are currently studying whole body calorimetry in several cancer types to determine the frequency and degree of hypermetabolism and its relationship to tumor burden, nutrient intake, weight loss, and response to therapy.

Management of Cancer Cachexia

Enteral and parenteral hyperalimentation are successful methods of overcoming non-cancer related cachexia and are in widespread use. We have attempted to apply these techniques to undernourished cancer patients in studies comparing cancer and non-cancer patients and in advanced colon cancer patients randomized to total parenteral nutrition (TPN) versus ad lib feeding.

In the latter randomized study,[3] we found that TPN was well tolerated, that patients gained weight, that this weight was not lean body mass but rather water and perhaps fat, that chemotherapy response rates to 5FU and methyl CCNU were not improved, and that survival was not prolonged by TPN. No evidence of tumor growth stimulation during TPN was seen. When we compared cancer and non-cancer cases[4] on enteral and parenteral hyperalimentation, we found that cancer cases were inferior to the non-cancer controls in repletion of lean body mass but not in repletion of fat and that retention of magnesium and phosphate was subnormal in cancer patients.

Our understanding of the exact frequency, relative importance, and precise mechanisms of the possible causes of cancer cachexia remains rudimentary.

Thus, it seems that while both cancer and non-cancer patients can replete fat stores, the ability of cancer patients to restore normal lean body mass is impaired. Whether this means that hyperalimentation leads to increased uptake and utilization of nutrients by the tumor is unclear.

A distinction should be made between hyperalimentation as part of a controlled, randomized study and non-volitional feeding of the cancer patient who cannot eat (esophageal cancer, for example) or who has malabsorption (i.e., surgical short gut syndrome). Feeding the latter patients is certainly reasonable. Additional work is necessary to devise effective techniques to replete the larger numbers of cancer patients who become undernourished through less obvious mechanisms.

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WHY AMA? Now, for the first time there's a forum for hospital medical staffs to meet nationally to discuss common problems and changes in physician-hospital relationships. The Hospital Medical Staff Section was recently created by the AMA to provide leadership in ensuring quality patient care during this period of massive hospital restructuring. It's one more good reason why you should be a part of the AMA.

WHY AMA? Commitment to maintaining high quality at all levels of medical education is one of the AMA's proudest traditions. The AMA creates policy for medical education, participates in accreditation activities, and supplies the public with information on medical education issues. Proven dedication to high standards in medical education: it's one more good reason why you should be a part of the AMA.

To Join, Contact your county or state medical society or write: Division of Membership, AMA, 535 North Dearborn Street, Chicago, Illinois 60610 or call collect, (312) 751-6196.

AMA
AMERICAN MEDICAL ASSOCIATION

president's letter



Toward Better Understanding

I KNOW THAT ALL of us who were privileged to attend the Legislative Seminar at Amelia Island in October of 1983 join me in extending heartfelt thanks to our faculty who took the time from their extremely busy schedules to give us the finest civics lession available. Lieutenant Governor Zell Miller, Speaker of the House Thomas B. Murphy, Senators Roy Barnes, Richard Greene, and Ed Hine, and Representatives Tommy Chambless, George Hooks, and Bobby Phillips told us just about everything we always wanted to know about the nature and function of the Georgia legislature. Not only did we receive a comprehensive overview of the organization and mechanics of the legislative process, but we also received a very personal and informative insight into the personality and nuances of that process which cannot help but improve both our understanding and effectiveness in dealing with the legislature. It is terribly important for us both as individuals and as a profession to understand and appreciate the pressures directed at these people from so many angles and from so great a diversity of viewpoints. If we are able to have that understanding and to let our legislators know that we do have that understanding and appreciation, then I think it almost automatically follows that our relationships with them and effectiveness with them will be improved.

One fundamental fact needs to be stressed; for good legislators to be in place, they first must be elected. Help them.

William W. Moore, Jr., M.D.

NEW MEMBERS

Arensman, Frederick W., Richmond—ACT—PD/CD
Dept. of Pediatrics, Medical College of Georgia, Augusta 30912

Bendins, Karlis, Clayton-Fayette—ACT—GP
607 Fayetteville Rd., Jonesboro 30236

Dalal, Surinder P. S., Bibb—ACT—IM/PUD
770 Pine St., Ste. 460, Macon 31201

Desai, Usha P., Cobb—ACT—OBG
1660 Mulkey Rd., Ste. D, Austell 30001

Eden, Samuel W., Gwinnett-Forsyth—ACT—IM
4025 Lawrenceville Hwy., Lilburn 30207

Finch, Stuart M., Richmond—ACT—P
Medical College of Georgia, Augusta 30912

Harper, Robert M., Richmond—ACT—D
Dept. of Dermatology, Medical College of Georgia, Augusta 30912

Hendrix, Maecdnas B., Muscogee—ACT—ORS
1920 Warm Springs Rd., Columbus 31995

Hobson, Douglas P., Richmond—ACT—P
Dept. of Psychiatry, Medical College of Georgia, Augusta 30912

Holland, Wallace E., Jr., Georgia Medical—I & R—IM
Memorial Medical Center, Savannah 31403

Howard, Dennis R., Bibb—ACT—FP
Mercer University School of Medicine, Macon 31207

Jenkins, Dreama Sue (Ms.), Richmond—Student
625 Pleasant Home Rd., Apt. 98, Augusta 30907

Kudchadkar, Somanath G., Muscogee—Associate—DR
Martin Army Hospital, Fort Benning 31907

LaVigne, William E., Richmond—ACT—OBG
2042 Central Ave., Augusta 30904

Linatoc, Cheryl A. (Ms.), Richmond—Student
Box H, Medical College of Georgia, Augusta 30909

Loeffler, Janice H., South Georgia—ACT (N-2)—PD
2704 N. Oak St., Bldg. J, Valdosta 31601

McCoy, Michael J., Carroll-Haralson—ACT (N-2)—OBG
Box 1668, Carrollton 30117

McKernan, J. Barry, Cobb—ACT—GS
130 Vann St., Ste. 220, Marietta 30060

McMichael, Alice O., Richmond—ACT—P
3643 Walton Way Extension, Augusta 30909

Morrissy, Raymond T., MAA—ACT—PD
1001 Johnson Ferry Rd., NE, Atlanta 30363

Osman, Magdy A., Georgia Medical—ACT (N-2)—FP
Candler Professional Bldg., Ste. 204, 5354 Reynolds St., Savannah 31405

Patel, Dilip T., Randolph-Stewart-Terrell—Act (N-1)—IM
P. O. Box 753, Dawson 31742

Rodriquez-Torres, José O., Richmond—I&R—PD
Box 1405, Medical College of Georgia, Augusta 30904

Rumm, Peter D. (Mr.), Richmond—Student
School Box H, Medical College of Georgia, Augusta 30902

St. Amant, William C., Cherokee-Pickens—ACT (N-2)—EM
R. T. Jones Memorial Hospital, Canton 30114

Segall, Nathan, MAA—ACT—A/IM
478 Peachtree St., Ste. 207-A, Atlanta 30308

Shah, Kamla, Richmond—ACT—TR
Radiation Therapy Center, Medical College of Georgia, Augusta 30912

Sherrill, Reginald R., Whitfield-Murray—ACT (N-1)—PS
1111 Professional Blvd., Dalton 30720

Tilson, Paul J., Ogeechee River—ACT (N-2)—U
422 Northside Dr., East, Ste. 300, Statesboro 30458

Umpierre, Jorge E., Cobb—ACT (N-2)—PD
833 Campbell Hill St., Ste. 360, Marietta 30060

Varnam, Gerald S., Cobb—ACT—IM
280 Interstate North, P. O. Box 105103, Atlanta 30067

Wattanawanakul, Somak, Randolph-Stewart-Terrell—ACT—R
Terrell County Hospital, Dawson 31742

Weaver, Leslie L., Gordon—ACT (N-2)—PTH
Gordon Hospital, Calhoun 30701

Wilson, Richard H., Muscogee—ACT (N-2)—PS
2200 North Ave., Columbus 31907

PERSONALS

First District

Savannah physicians, **Joseph W. DeHaven, M.D.,** and **Michael L. Nash, M.D.,** were elected to Fellowship in the American College of Physicians.

Irving Victor, M.D., urologist, was named to the new post of Vice President of Medical Affairs at Memorial Medical Center in Savannah.

Albert M. Deal, M.D., was chosen by Georgia Southern College as the recipient of the school's 1983 Distinguished Alumni Award in Biology.

Second District

Joseph M. Turner, M.D., was elected to Fellowship in the American College of Physicians.

Sammie D. Dixon, M.D., was appointed to the Georgia Health Policy Council by Governor Joe Frank Harris.

Third District

Dennis R. Thomas, M.D., recently opened a new practice in Washington, Georgia.

Fourth District

G. Douglas Talbott, M.D., program director for Adult and Adolescent Chemical Dependency Programs at Ridgeview Institute, Smyrna, was guest speaker at the November meeting of the Douglas County Medical Society and the Douglas County Bar Association.

Andrew Morley, M.D., and **Lawrence Freeman, M.D.,** were named president-elect and vice president, respectively, of the Georgia Academy of Family Physicians.

Fifth District

Jonne B. Walter, M.D., was elected to Fellowship in the American College of Physicians.

Edward J. Planz, M.D., a specialist in cardiovascular medicine, has joined the medical staff at Parkway Regional Hospital.

Northside Hospital has named **James Estes, M.D.,** chairman of the medical staff, **John E. Lee, M.D.,** vice chairman, and **Charles G. Rogers, M.D.,** secretary-treasurer for 1984.

Ivan A. Backerman, M.D., was named a Fellow of the International College of Surgeons.

College Park physician, **Walker L. Curtis, M.D.,** has been chosen to appear in *Who's Who in Georgia, 1983-84*.

Nanette K. Wenger, M.D., F.A.C.C., will serve as program director for a 3-day program on "Rehabilitation of the Coronary Patient," scheduled for February, 1984, in Bethesda, MD.

Seventh District

William F. Wieland, M.D. was named medical director of Community Psychiatric Center's Peachtree-Parkwood Hospital.

William C. Patterson, M.D., of Smyrna, retired from his surgical practice on November 15.

Dalton physician, **Drayton Sanders, M.D.** was inducted as a Fellow in the American College of Chest Physicians.

Eighth District

Donald Waters, M.D., of Blackshear, was elected alternate director of the Georgia Academy of Family Physicians in the Eighth District.

Reuben Roberts, M.D., was elected director of the Georgia Academy of Family Physicians for the Eighth District.

O. O. McGahee, Jr., M.D., was elected to the American Academy of Family Physicians Congress of Delegates.

Ninth District

Clayton physician, **John E. Fowler, M.D.,** was recently elected President of the Georgia Academy of Family Physicians.

Elton L. Copelan, M.D., has recently returned from a 17-day medical tour of the People's Republic of China. He attended the Sino American Joint Conference of Obstetrics and Gynecology sponsored jointly by Boston University School of Medicine, the China Medical Association, and the Chinese Academy of Medical Sciences.

DEATHS

John Mooney, Jr., M.D.

John Mooney, Jr., M.D., of Statesboro, died November 10. Dr. Mooney was co-founder and retired medical director of Willingway Hospital. He was a graduate of Emory University School of Medicine. Dr. Mooney was the 1983 recipient of the Georgia Addiction Council Association Service Award. In 1971, he was chairman of the governor's Alcohol Study Commission and served on the Alcoholism Advisory Council Board and the Georgia Alcohol and Drug Abuse Council. In addition, Dr. Mooney served on the National Council on Alcoholism and the American Society of Alcoholism.

He is survived by his wife, one daughter, three sons, and two sisters.

Ronald R. Rooney, M.D.

Ronald R. Rooney, M.D., formerly of Marietta, was shot to death in a holdup November 4 while he and his wife were vacationing in Acapulco, Mexico. Dr. Rooney was a graduate of Emory University School of Medicine. He was former president of the Cobb County Medical Society, the Atlanta Radiological Society, and the Georgia Radiological Society.

He was also a member of the Radiological Society of North America and the International Congress of Radiology. Dr. Rooney served on the Board of Chancellors, and was a former vice president of the American College of Radiology. At the time of his death, he was serving as president of the staff of Bartlett Memorial Hospital and had been appointed to the post of secretary of the Alaska State Medical Board by the governor of Alaska.

Survivors include his wife, two daughters, and two sons.

Committee Activities . . .

Highlights — MAG Executive Committee Meeting, December, 1983

Maternal & Infant (M&I) Health Task Force — At the November, 1983, Executive Committee (EC) meeting, a report of the activities of the M&I Task Force on Infant Mortality in Georgia was presented. Because of the extensive content of this report, the EC deferred it to the December meeting in order that the report could be thoroughly reviewed and an equitable response be given to the M&I Task Force before their meeting in January. Following discussion of specific suggestions presented by the Task Force, the EC approved the report as presented.

In another discussion, Dr. Charles Hollis brought to the Committee's attention that OB-GYN physicians were beginning to have a number of suits brought against them with a resulting increase in their liability insurance premiums. Dr. Hollis pointed out that to increase participation by obstetricians in programs to improve OB care for medically indigent patients would require some relief from the burden or threat of increased malpractice exposure. Following discussion, the EC requested the Third Party Relations Committee to urge the Department of Medical Assistance in Georgia to use the present arbitration law, which is now on the books in Georgia, to assist OB-GYN physicians when they accept the indigent patients under this program.

Committee on Legislation — The Chairman of MAG's Committee on Prison Health Care, Robert DeJarnette, MD, forwarded to the EC a 1984-85 budget requesting that MAG approve an additional professional position, preferably a registered nurse, to be added to the current staff of the Prison Health Care Committee, and the Committee further agreed that the current 25% secretarial position should be increased to 50% time commitment. The budget included no increase in the travel budget, although it was expected to double the current amount, with two full-time staff persons. The Prison Health Care Committee expected that the accreditation fees currently being collected from facilities desiring accreditation will more than cover the increased amount necessary for travel and perhaps assist in providing a fifth symposium during the next year. After discussion, the EC approved the concept in Dr. DeJarnette's memorandum, provided constracts to guarantee the income needed to enlarge the program can be certified.

AMA President-Elect Visit in 1984 — Dr. Bill Moore reported that he had invited Joseph Boyle, MD, President-Elect of the AMA, to attend the April meeting of the MAG House of Delegates. Dr. Boyle has accepted this invitation.

Committee Appointments — The EC approved the appointment of S. Reaves Lee, MD, Psychiatrist, Atlanta, as a member of the MAG Impaired Physicians Committee. The EC also appointed Ronald Kaplan, MD, to serve as a member of the Emergency Medicine Services Committee, and at the same time, reiterated that Dr. Rodger Chapman would be Chairman when he was fully instated as a member of MAG.

Professional Review Organization — The Secretary reported that the Georgia Medical Care Foundation (GMCF) anticipated offering its plan the early part of 1984 outlining the specifics by which it will fulfill the requirements of the Contractor under the PRO Contract soon to be awarded. GMCF is appointing a Committee whose job will be to design review proposals and translate the requirements to be imposed by the Federal Government into a specific review process to be administered by the Foundation. This Committee will serve in an advisory capacity to the GMCF Board of Directors. The Foundation requested MAG to select six physicians to serve on this committee along with six representatives from the Georgia Hospital Association. The EC nominated the following physicians to serve on the GMCF Advisory Council: M. D. Pittard, MD, Toccoa; Ollie O. McGahee, MD, Jesup; W. Earl Bobo, MD, Decatur; Harry N. Dorsey, MD, Albany; George J. Everidge, MD, Columbus; and Bob G. Lanier, MD, Atlanta. It was understood by the EC that if any of the above physicians were unable to serve on this committee, Doctors Moore and Logan were authorized to submit any other names they deemed desirable.

Professional Liability Workshops — The EC voted that St. Paul's Insurance Company and MAG Mutual Insurance Company be approached by J. Rhodes Haverty, MD, to seek a 2-year discount on professional liability premiums for those physicians taking the second series of Risk Management Workshops.

DHR Representative — Dr. Bill Moore brought to the Committee's attention the need for MAG to discuss matters of mutual interest with the MD representatives of the DHR Board. Following discussion, the EC voted that all MD members of the DHR Board meet with the MAG EC in February, 1984, to discuss ways and means by which MAG might help the MD members in their dealings with DHR matters.



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Composite State Board of Medical Examiners' Disciplinary Actions

At the request of the Composite State Board of Medical Examiners (the "Board"), the Medical Association of Georgia has agreed to publish the results of disciplinary actions of the Board as a public service to inform physicians throughout the State of Georgia of the actions taken by the Board.

The disciplinary actions described below constitute the actions taken by the Board and are subject to appeal by the physicians involved to an appropriate superior court pursuant to the terms of the Georgia Administrative Procedure Act.

The following actions were taken between July 1 and September 30, 1983. The Board typically includes several provisions in an Order which are not summarized here. You are advised that *you should not take any adverse action against a physician based on this report;* you should request a copy of the public order from the Board, and evaluate that document before making any decisions affecting any of these physicians. This listing does not reflect pending appeals.

Consent Orders

Herbert I. Garfield, M.D., Port St. Joe, FL
George T. Henry, M.D., Barnesville, GA
Gerald B. Hogsette, M.D., Sylvania, GA
Edward Holt, M.D., Adel, GA
Julian Johnson, M.D., Atlanta, GA
Stephen Kutner, M.D., Atlanta, GA
Everett M. Lee, M.D., Atlanta, GA
Peter M. Macaluso, Tallahassee, FL
William McKenzie, M.D., Atlanta, GA
Douglas E. Ott, M.D., Terre Haute, IN
Carl E. Sills, M.D., Cuthbert, GA
Hameed U. Subhani, M.D., Vidalia, GA
George Allen Sullivan, D.O., Dyer, TN
Mohamed G. Taleb Agha, M.D., Buchanan, GA
In Whan Yun, M.D., Wrens, GA

License Restored

J. Hoyt Young, M.D., Atlanta, GA

License Probation

Richard Bennett Rubin, M.D., Dothan, AL
Fred Vidal, M.D., Franklin, NC

Voluntary Surrender

Irving I. Green, M.D., Atlanta, GA
Arthur B. Rhoades, M.D., Lake Charles, LA





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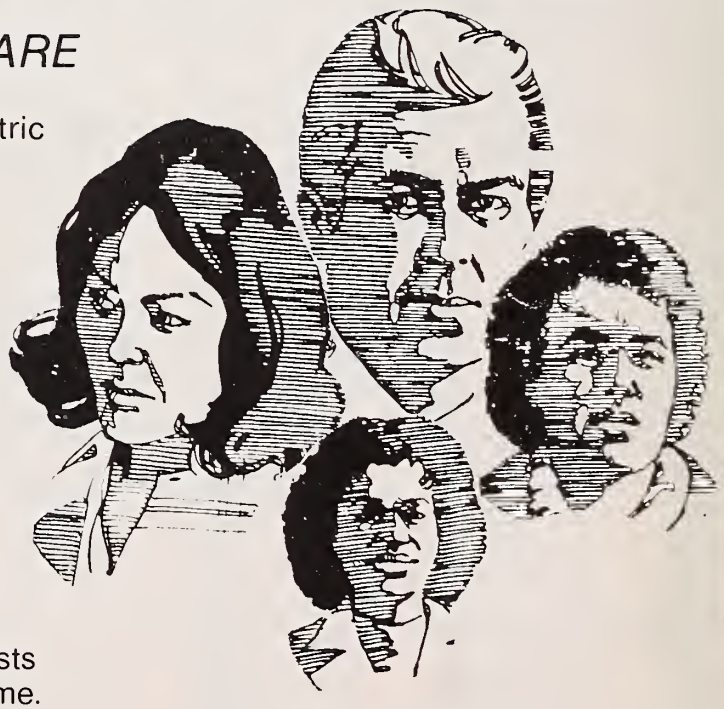
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Building 128
Fort McPherson, GA 30330
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of the medical association of georgia
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> Soter NA, Wasserman SI, Austen KF. Cold urticaria release into circulation of histamine and eosinophil chemotactic factor of anaphylaxis during cold challenge. N Engl J Med 1976;294:687-90.

NEWS NOTES — District and county medical societies, Association members, and readers are invited to send in any news items of general concern to members of the Medical Association of Georgia.

REPRINTS — Requests for reprints should be made directly to The Ovid Bell Press, Inc., 1201-05 Bluff Street, Fulton, Missouri 65251. Reprints must be ordered within 30 days after publication, since all type will be destroyed after that time.

ILLUSTRATIONS — Illustrations must be submitted in duplicate. Illustrations, tables, etc., should bear the author's name and figure number. Used photographs, drawings and cuts will be returned after publication only if requested. The cost of reproduction of illustrated material for publication in excess of three average illustrations and/or tables will be borne by the author, and the *Journal* will bill the author for this expense.

GENERAL POLICY — Authors will be given as wide a latitude as the general policy of the *Journal* and the demands on its space permit. The right to reduce, revise, or reject any material submitted for publication is always reserved. The *Journal* is not responsible for statements made by any contributor. All communications regarding editorial, advertising, subscription, and miscellaneous matters should be sent to The Editor, 938 Peachtree Street, N.E., Atlanta, GA 30309-3990.

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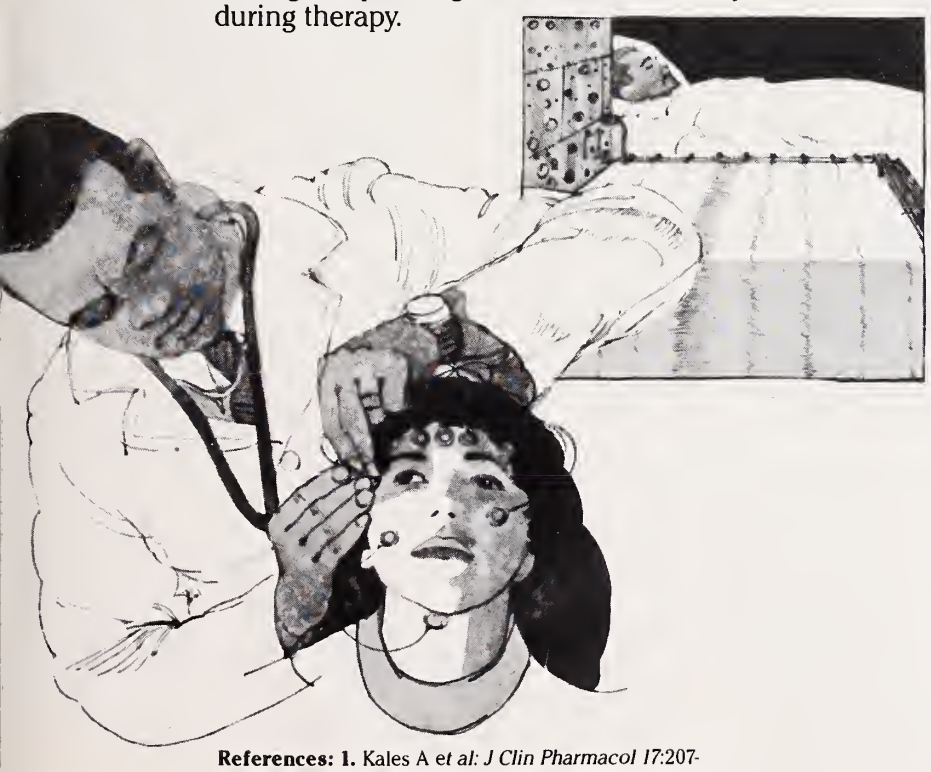
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References: 1. Kales A *et al: J Clin Pharmacol 17*:207-213, Apr 1977 and data on file, Hoffmann-La Roche Inc., Nutley, NJ. **2.** Kales A: Data on file, Hoffmann-La Roche Inc., Nutley, NJ. **3.** Zimmerman AM: *Curr Ther Res 13*:18-22, Jan 1971. **4.** Kales A *et al: JAMA 241*:1692-1695, Apr 20, 1979. **5.** Kales A, Scharf MB, Kales JD: *Science 201*:1039-1041, Sep 15, 1978. **6.** Kales A *et al: Clin Pharmacol Ther 19*:576-583, May 1976. **7.** Kales A, Kales JD: *Pharmacol Physicians 4*:1-6, Sep 1970. **8.** Frost JD Jr, DeLucchi MR: *J Am Geriatr Soc 27*:541-546, Dec 1979. **9.** Dement WC *et al: Behav Med 5*:25-31, Oct 1978. **10.** Vogel GW: Data on file, Hoffmann-La Roche Inc., Nutley, NJ. **11.** Karacan I, Williams RL, Smith JR: The sleep laboratory in the investigation of sleep and sleep disturbances. Scientific exhibit at the 124th annual meeting of the American Psychiatric Association, Washington, DC, May 3-7, 1971. **12.** Pollak CP, McGregor PA, Weitzman ED: The effects of flurazepam on daytime sleep after acute sleep-wake cycle reversal. Presented at the 15th annual meeting of the Association for Psychophysiological Study of Sleep, Edinburgh, Scotland, June 30-July 4, 1975. **13.** Data on file, Hoffmann-La Roche Inc., Nutley, NJ.

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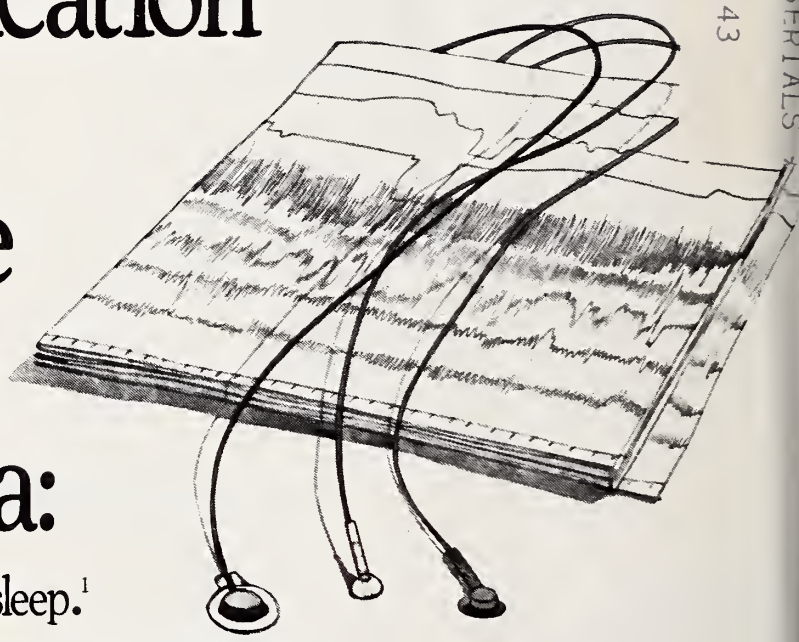
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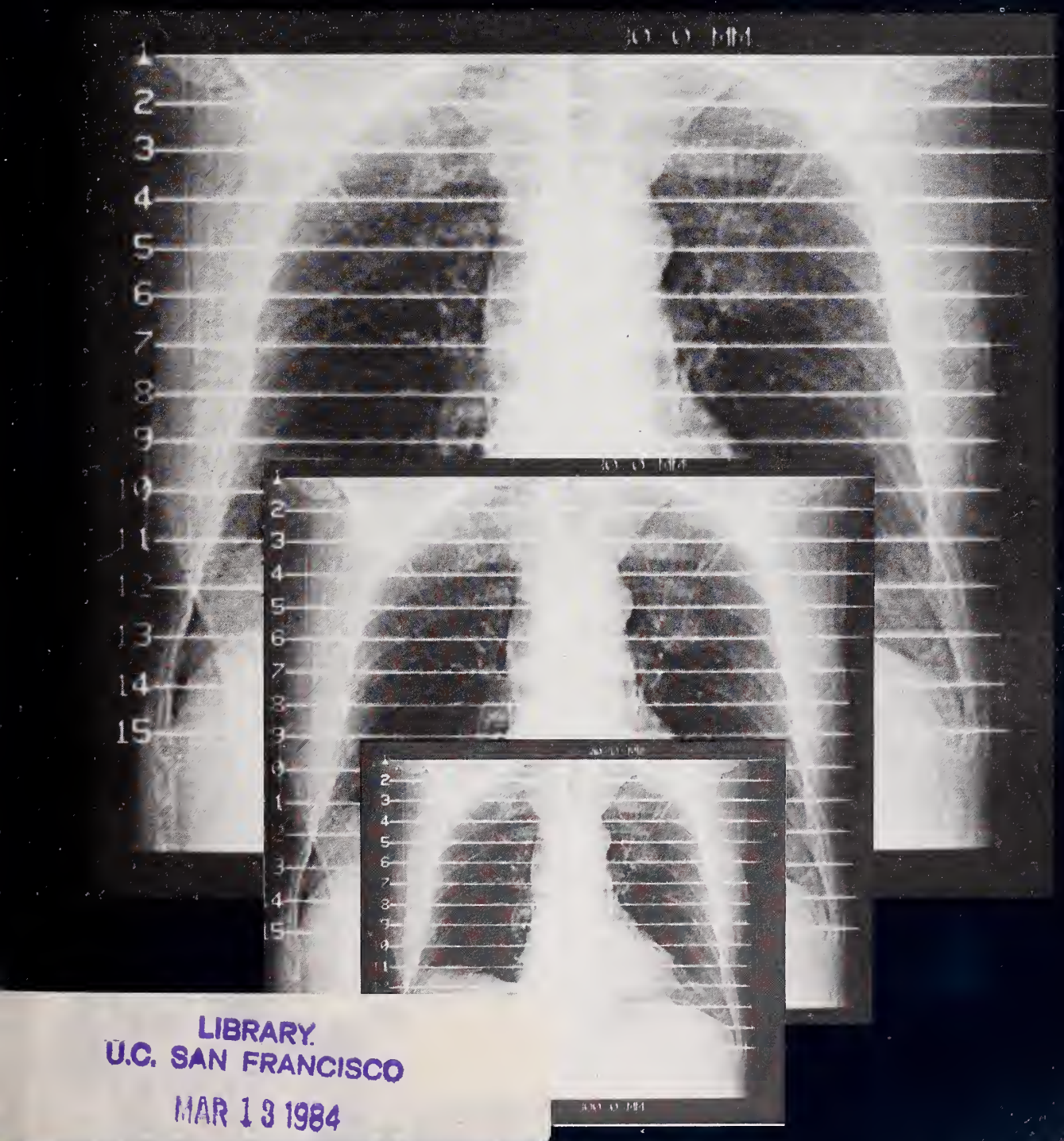
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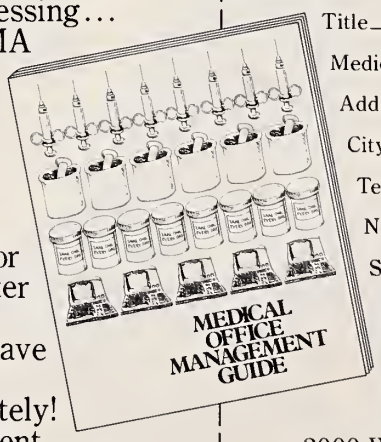
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The subscription price per year for members of the Medical Association of Georgia is $7.50, included in the annual membership dues. The subscription price for nonmembers is $15.00 in the United States, Canada and Mexico, and $17.00 in other countries. Single copies are $2.

The *Journal of the Medical Association of Georgia* is published monthly at 938 Peachtree Street, N. E., Atlanta, GA 30309-3990. Second-class postage paid at Atlanta, Georgia, and at additional mailing offices. POSTMASTER: Send address changes to Medical Association of Georgia, 938 Peachtree Street, N. E., Atlanta, GA 30309-3990.

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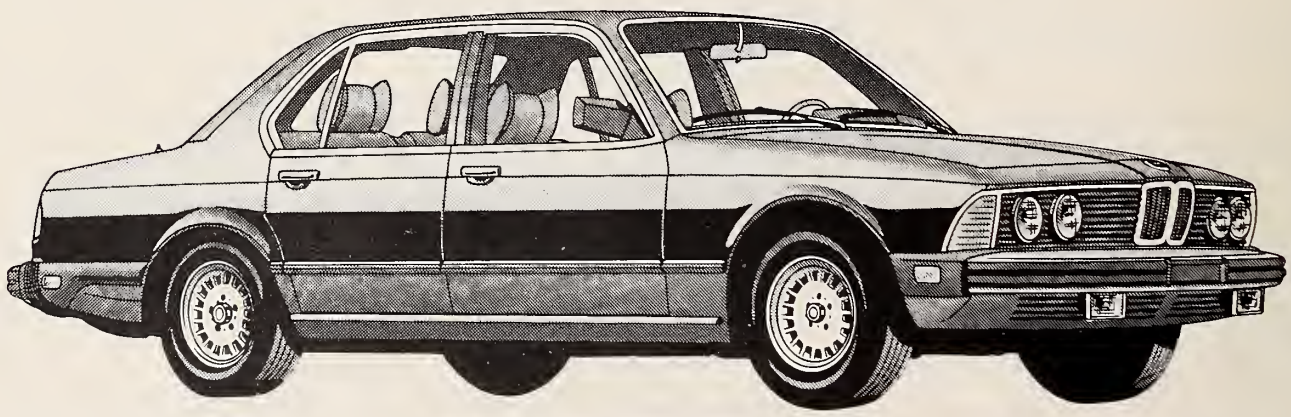
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18-25—*Park City, Utah:* **2nd Annual Winter Urology Seminar.** Category 1 credit. Contact Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., NE, Atlanta 30322. PH:404/329-5695.

20-25—*Augusta:* **19th Annual Family Practice Symposium.** AMA Category 1 and AAFP prescribed credit. Contact Div. of Cont. Ed., MCG, Augusta 30912. PH:404/828-3967.

23-24—*Atlanta:* **Once a Month: Update on Premenstrual Syndrome.** Contact Bonnie H. Lawson, Ph.D., Georgia Center for Continuing Education, Univ. of Ga., Athens 30601. PH:404/542-7553.

24—*Atlanta:* **Clinical Problems in Neurology.** Category 1 credit. Contact Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., NE, Atlanta 30322. PH:404/329-5695.

25-26—*Atlanta:* **OB/GYN Risk Management Seminar.** Contact Chester Lane, Exec. Secy., Ga. State OB.-GYN. Society, 69 Butler St., SE, Atlanta 30303. PH:404/588-3540.

27-Mar. 2—*Paradise Island, Nassau, Bahamas:* **Problems of Chronic Pain.** Category 1 credit. Contact Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., NE, Atlanta 30322. PH:404/329-5695.

MARCH

2—*Atlanta:* **Nutrition in the Later Years.** Contact Ann Robinson, Coll. of Health Sciences, Box 873, Ga. State Univ., Atlanta 30303. PH:404/658-3085.

4-10—*Keystone, CO:* **Snow Job in OB/GYN.** Category 1 credit. Contact Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., NE, Atlanta 30322. PH:404/329-5695.

6-9—*Durango, CO:* **Seventh Annual Symposium on Emergency Medicine.** Category 1 and AAFP prescribed credit. Contact Div. of Cont. Ed., MCG, Augusta 30912. PH:404/828-3967.

14-16—*Atlanta:* **American Society for Clinical Pharmacology and Therapeutics.** Contact ASCPT, 1718 Gallagher Rd., Norristown, PA 19401. PH:215/825-3838.

23-24—*Savannah:* **MAG Risk Management Seminar.** Category 1 credit. Contact Ms. CaRita Connor, Georgia Medical Society, P. O. Box 5716, Savannah 31404. PH:912/355-6607.

APRIL

2-3—*Atlanta:* **Nutrition, Eating, and Behavior.** Contact Ann Robinson, Coll. of Health Sciences, Box 873, Ga. State Univ., Atlanta 30303. PH:404/658-3085.

4-6—*Atlanta:* **Techniques in Orthopaedic Surgery.** Category 1 credit. Contact Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., NE, Atlanta 30322. PH:404/329-5695.

5-7—*Atlanta:* **Introduction Into Percutaneous Transluminal Angioplasty III.** Category 1 credit. Contact Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., NE, Atlanta 30322. PH:404/329-5695.

6-7—*Callaway Gardens:* **4th Annual Geriatric Conference For Primary Physicians.** Category 1 credit. Contact Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., NE, Atlanta 30322. PH:404/329-5695.

8-12—*Atlanta:* **American Association of Neurological Surgeons.** Contact AANS, 625 N. Michigan Ave., Ste. 1519, Chicago, Il 60611. PH:213/944-4205.

9-12—*Atlanta:* **Demonstrations In Percutaneous Transluminal Angioplasty XI.** Category 1 credit. Contact Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., NE, Atlanta 30322. PH:404/329-5695.

12-14—*Atlanta:* **Pharmacology for the Anesthesiologist.** Category 1 credit. Contact Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., NE, Atlanta 30322. PH:404/329-5695.

14-15—*Atlanta:* **The Cardiac Patient: Management for Cardiopulmonary Bypass.** Category 1 credit. Contact Dir., Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., NE, Atlanta 30322. PH:404/329-5696.

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26-29—*Atlanta:* **MAG House of Delegates.** Contact J. Tom Sawyer, MAG, 938 Peachtree St., NE, Atlanta 30309. PH:404/876-7535 or 800-282-0224 (toll free in Ga.).

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Letters to the Editor . . .

Dissent re Homosexuality

Dear Sir,

I'm writing in response to Dr. Alfred Messer's editorial "A Current Perspective on Homosexuality" in November, 1983, *Journal*. I appreciate that as an editorial, it was just Dr. Messer's personal opinion. Also, it is curious that he used an analogy with obesity. I'm not an expert on obesity, but I believe it is conceded that if a person has been overweight since childhood and has parents who were overweight, his/her chance of being slim, (American society's currently favored shape) is very unlikely. Therefore, it would be unwise to tell this person that we doctors could make him/her slim. Also, with homosexuality, if a person has been gay since early adolescence and is a Kinsey 5 or 6 (predominantly to exclusively homosexual), the chance of a conversion to heterosexuality is generally conceded to be about nil to impossible. Therefore, to hold out change is medically unsound and undermines society's confidence in medicine, which is exactly what has happened to psychiatry in the gay community.

I will not address all the erroneous stereotypical remarks made by Dr. Messer, but will highlight only a few:

1) Recent research actually shows older gay men, especially compared to widowers, to be less lonely and depressed than their heterosexual controls.

2) Studies do not confirm "that homosexuals have a deep-seated fear of women"; in fact, there are many close and mutually gratifying relationships between gay men and straight women.

3) Concerning Messer's statement that "the homosexual . . . frequently expresses nonsexual needs through his homosexual relationships," most therapists realize that persons of whatever sexual orientation express nonsexual needs through sexual behavior *and* consider it an example of human ingenuity and adaptiveness.

4) Concerning the often misunderstood "vote" by the American Psychiatric Association, Dr. Judd Marmor, past President of the APA, says that the decision to remove homosexuality as an illness was handled "in the normal way in which the APA handles all such emerging issues" . . . based on the . . . "scientific issues involved" and "none of these steps involved or were motivated by pressure from gay activists."[1] The removal from the DSM II would have rested after the Board of Trustees' ratification of other committees' recommendations, but "opponents marshalled the necessary two hundred signatures to compel a referendum of the entire membership of the APA," which upheld the Board of Trustees' decision by 58% majority. Thus the "vote" was not part of the scientific and rational process, but was a political maneuver.[2]

5) As psychiatrists, we do not understand the *basis* of homosexual behavior any more than we do the basis for heterosexual behavior. There are psychoanalytical and other theories, but many feel these reflect cultural bias and homophobia of the theorist.

6) Dr. Messer's strongest plea is the tired one of preserving the family. Does Dr. Messer feel heterosexuality, family and population growth is so tenuous that gays must be scapegoated for these to flourish? Homophobia may well be one of the forces contributing to stress in the male with many physical and emotional complications, including a failure to adapt to evolving family roles.[3]

Although Dr. Messer comments "homosexual individuals should not be persecuted," he sounds like he is doing exactly that himself.

Sincerely,
Edward O. Nix, M.D.
Psychiatrist, Atlanta

1. Marmor J. Epilogue: homosexuality and the issue of mental illness. In, Homosexual Behavior, A Modern Reappraisal, N.Y. Basic Books, 1980.
2. Marmor J. Loc, Cit. and Personal Communication.
3. Pleck JH. The Myth of Masculinity, M.I.T. Press, 1981.

Dear Sir:

I am deeply appalled that you show such editorial policy that allows Dr. Messer the opportunity to write such unethical and unscientific material for the *Journal of the Medical Association of Georgia*. Dr. Messer should be an embarassment to the APA as well as to the state of Georgia. I certainly hope that the medical community in Georgia does not think that this represents "The Current Perspective on Homosexuality."

Sincerely,
David E. Harris
Project Coordinator
AID Atlanta

Book Review . . .

The Medical Profession in Georgia 1733-1983

EVELYN WARD GAY

This monumental work by Evelyn Ward Gay (Mrs. Brit B., Jr.) pictures with amazing detail the history of the medical profession in Georgia for the 250 years of the state's existence. It is beautifully written, remarkably well documented, most informative, and of great interest throughout.

The book can be readily divided into several periods. The first period, that of the Eighteenth Century, describes the unbelievable hardships of all kinds to which the early colonists were subjected: the very poor housing, the shortage of food with resulting poor nutrition, fevers and other illnesses of all kinds, and the total lack of adequate medical care and the devastating number of fatalities. Considerable space is given to the military, legal, and political activities of the early colonists and to some of the great personalities of that time who are still remembered.

The Nineteenth Century portion describes the beginning of organized medicine and the widespread formation of medical societies throughout the state, beginning with the Georgia Medical Society in Savannah in 1804. The difficulties encountered by the profession led to the recognition of the need and necessity for more and better medical education. The author tells of the founding of a number of medical schools in the state and the requirement of a longer period of study to obtain a medical degree. The improvement in medical education brought about the construction of hospitals, the formation of public health boards, increased interest in preventive medicine, and the constant study and effort to find the cause of and to control the terrible epidemics of yellow fever and other fevers which occurred frequently. The introduction of anesthesia which greatly broadened the scope of surgery is also discussed.

The devastating effect of the Civil War on the South and the part Georgia doctors took in the conflict and the role medicine played in the restoration of the country is documented as is the medical care of the freed slaves.

The modern period of the Twentieth Century is brilliantly portrayed. The development of the great medical schools in Atlanta and Augusta and their positive influence on the progress of today's medicine and its wonders are included.

The organization of dentists and pharmacists, the advent of women into the field of medicine, and the tremendous effect these have had on the medical profession is well and adequately covered.

Mrs. Gay includes a section on the accomplishments and literary contributions of many well recognized members of the medical profession in Georgia.

In telling the story of Georgia's medical profession, the author has included so much interesting contemporary history of early Georgia so as to render the book most informative, entertaining, and worthwhile even if the medical profession were not mentioned.

Printed by The Ovid Bell Press, Inc., the book is a handsome volume of 391 beautifully printed pages with an additional 29 pages of notes, 10 pages of bibliography and an index of 15 pages. A number of interesting photographs are also included.



Evelyn Ward Gay (Mrs. Brit B., Jr.), author of *The Medical Profession in Georgia, 1733-1983*, is standing in front of the entrance to the original site of Noble Jones' Wormslow Plantation on the outskirts of Savannah. "Wormsloe" is now maintained as an historic site by the state of Georgia.

Mrs. Gay has had extensive experience writing for a variety of magazines and newspapers. She had contributed many stories to journals and other publications and is well known to the readers of the MAG *Journal*. Her full-length biography of Lucian Lamar Knight, founder of Georgia's Department of Archives and History, was published in 1967.

She has been married to a physician since he was in medical school. She is the mother of three children of whom she is justly proud: one son is a hematologist-oncologist, another son is a college professor, and her daughter is a medical editor in New York. She is the mother-in-law of a pediatrician and a psychiatric nurse, and the aunt of an ophthalmologist. She is a member of many journalist clubs and writer groups and also a member of a number of historic societies and other organizations.

Mrs. Gay says she does not consider herself to be an expert in any field and is not a trained historian (hard to believe). Her major college interest was not history but English and psychology. Before her marriage she was employed in social work, dealing with the indigent and handicapped. This latest book by Mrs. Gay deserves a place in everyone's library.

Julian K. Quattlebaum, Sr., M.D.
Retired General Surgeon, Savannah

The Medical Profession in Georgia
1733-1983

Evelyn Ward Gay — The Ovid Bell Press, Inc.
Fulton, Missouri — 447 pages — 15 photographs



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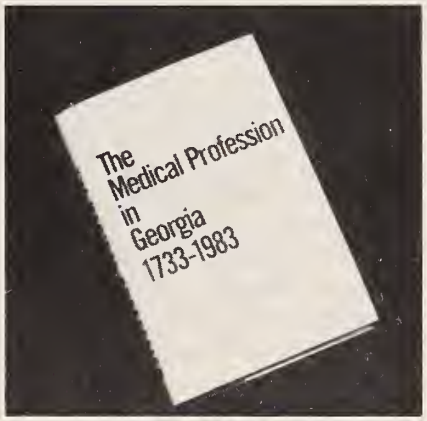
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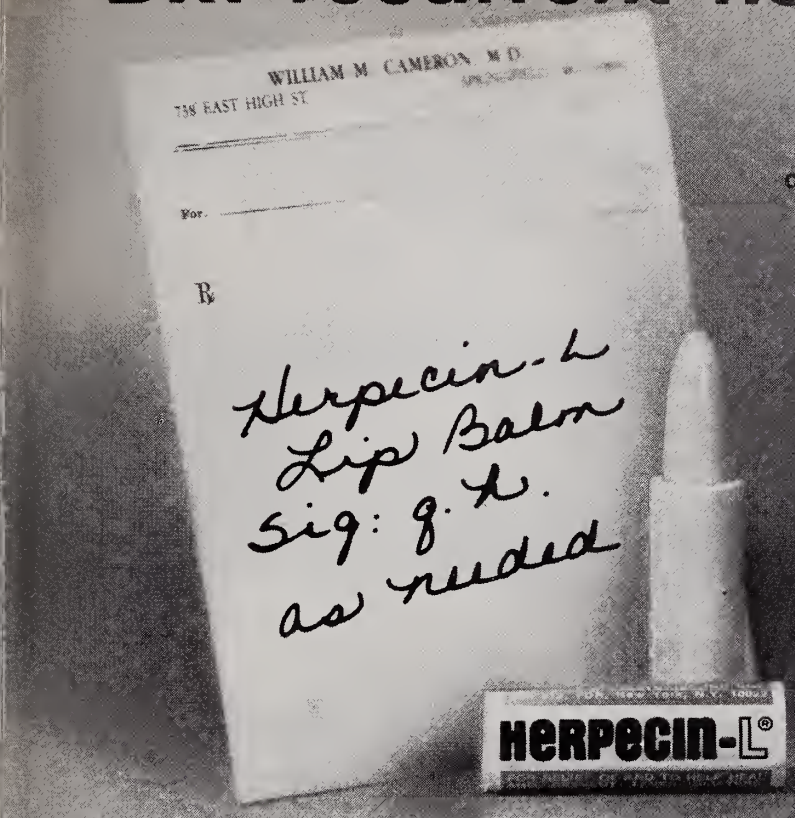


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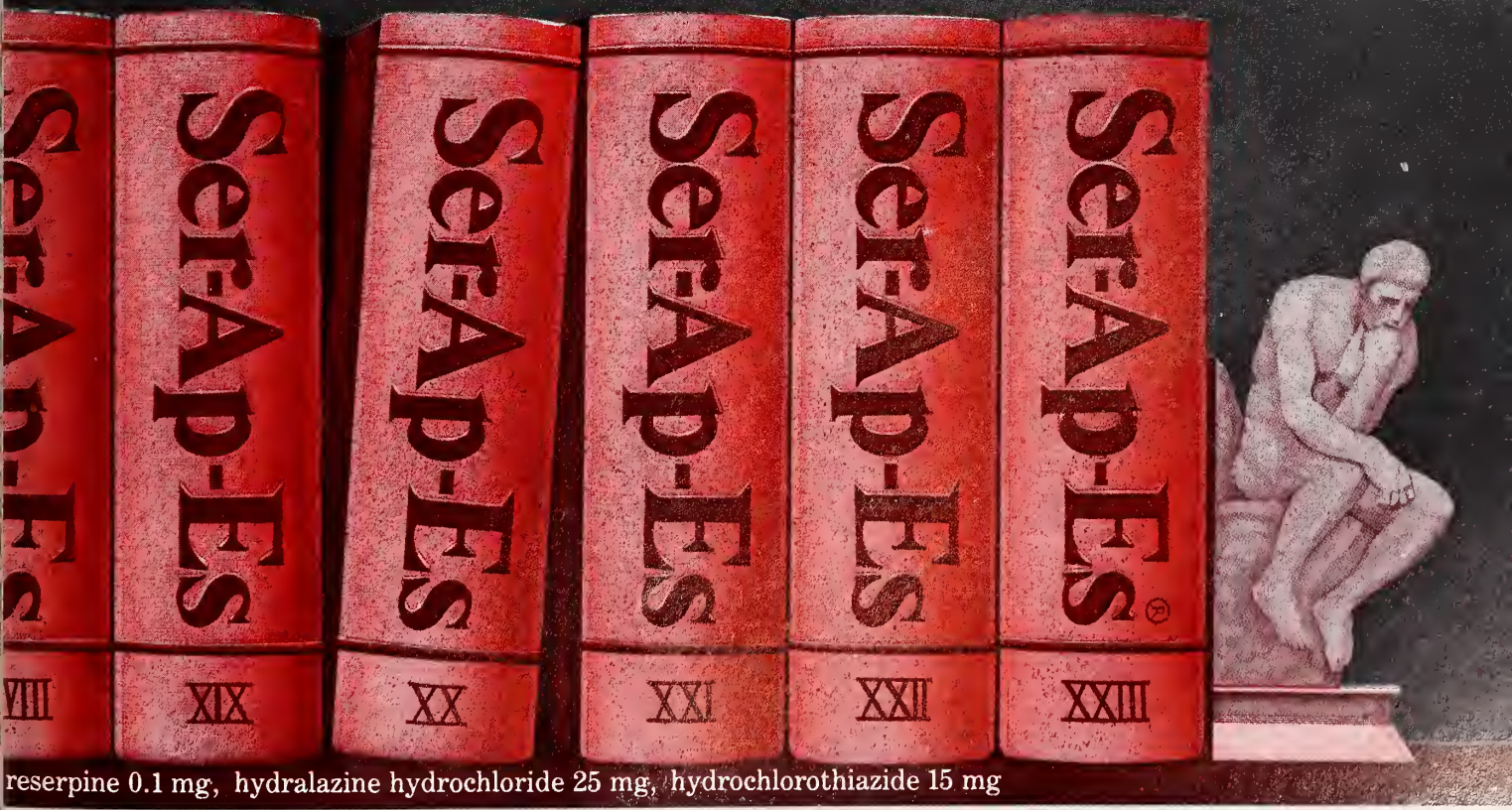
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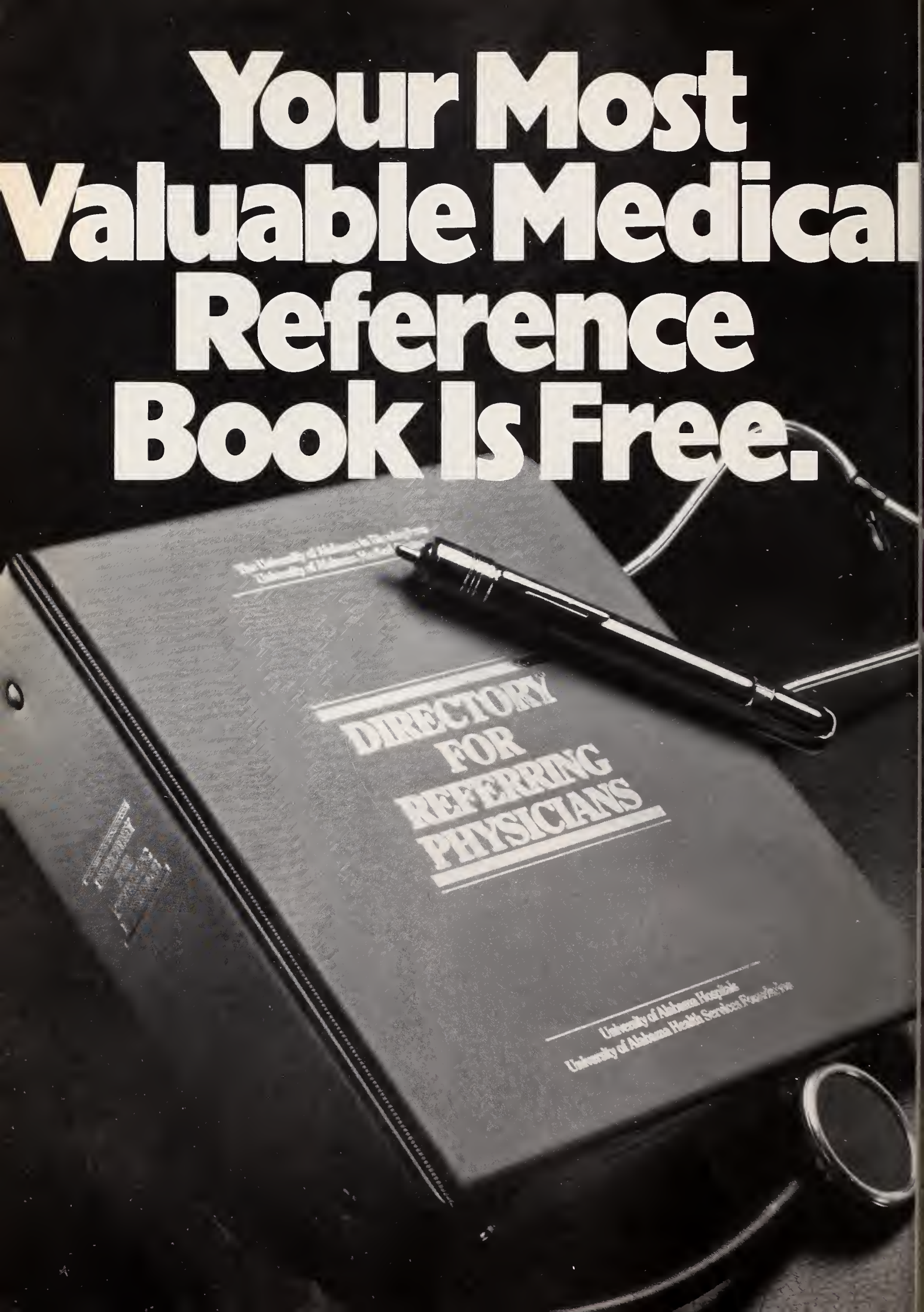
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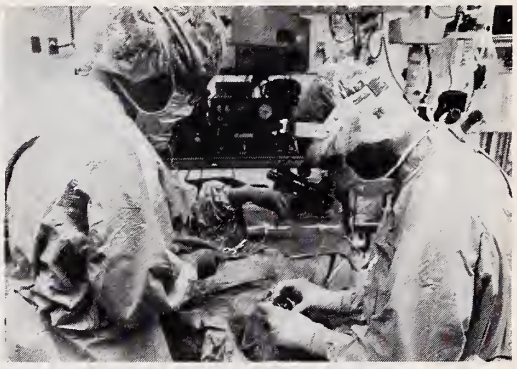
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Computed Tomography of the Chest: Current Indications

JAMES W. SOMOGYI, M.D., *Atlanta**

Introduction

The use of computed tomography (CT) in the diagnosis of diseases of the chest is controversial.[1, 2] Conventional radiography is already a sensitive, inexpensive, and widely available method of studying the thorax.

The advantages of CT are its sensitivity to small differences in radiographic density, the assignment of a density number to each portion of the image, and its display of anatomy in the transverse plane. Comparing chest CT with conventional studies, CT can provide unique information with significant clinical impact in about 40% of cases.[3-5] In some settings, CT can replace angiography or obviate surgery.

The radiation dose for chest CT is many times greater than for routine PA and lateral views. Compared to conventional tomograms, the dose may be greater or less depending on a number of technical factors. Because of the large initial expense of installing a CT unit, the examination cost is several times that of routine tomograms.

The purpose of this paper is to arrive at practical indications for chest CT from review of the recent literature and my experience over the past 3 years.

Technique

Several technical modifications of the CT exam are required in the chest. Respiratory motion can make small intrapulmonary nodules or disease near the diaphragm difficult to see. Ideally, the scanning time should be shorter than the patient's breath-holding ability. In order to make consecutive thin sections through a lesion, the patient should be instructed to reinflate his lungs to a constant volume between breaths. Endpoints at end expiration and deep inspiration have been used.

The density of a lesion is given in Hounsfield units (HU) where 50-60 HU is the density of blood, −100 HU the density of fat, and zero HU the density of water. Unfortunately, scanners of different manufacturers will not necessarily give identical density readings for a given lesion. In fact, an object placed in the margin of the scanning field as opposed to its center may show small changes in density.[6, 7] Therefore, calibration against a phantom of known density is required and comparison of density numbers cannot be interpreted in any absolute way.

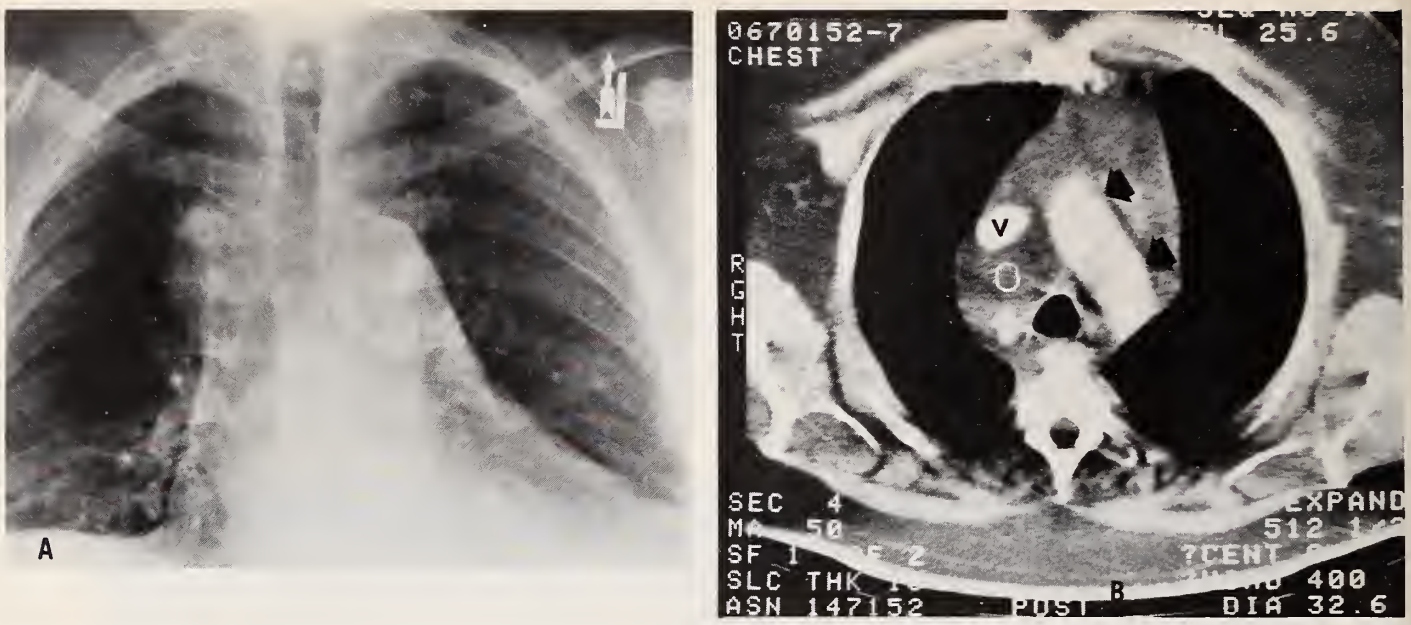
An intravenous bolus or drip of 50-100 cc iodinated contrast is often used to determine the vascularity of a lesion in patients with normal renal function without history of contrast reaction. For subtle vascular detail, such as the differentiation of pulmonary artery and veins from adjacent hilar nodes, a dynamic CT scan can be performed. An anatomic level of interest is chosen and scanned repeatedly while contrast is infused rapidly. This technique gives maximum contrast enhancement which can be quantified and graphed as a function of time.

Mediastinum

There are three general indications for CT in the mediastinum. Computed tomography can further characterize an obvious mass, detect an occult mass suspected by clinical history, or clarify an equivocal finding raised by the radiograph.

Mediastinal fat may have unusual locations and configurations, and the fatty density is often not apparent from the initial chest radiograph (Figures 1A&B). When the chest roentgenogram suggests a

* Dr. Somogyi is a Radiologic Consultant of Internal Medicine Group Atlanta. Send reprint requests to him at 478 Peachtree St., NE, Ste. 207-A, Atlanta, GA 30308.



Figures 1A & B — Mediastinal lipomatosis. (A) Radiograph of an obese 54-year-old man with non-productive cough of 1 month's duration shows superior mediastinal widening and a right paratracheal mass suspicious for neoplasm. (B) CT at the level of the aortic arch (arrows) shows extensive fat surrounding the trachea and superior vena cava (V). Mean density within the cursor (white circle) is −101 HU, the density of benign fat.

prominent epicardial fat pad, mediastinal lipomatosis, or omental fat herniated through a Bochdalek or other foramen, CT can confirm the diagnosis. Benign fatty lesions have a homogeneous appearance on CT, with density numbers in the −60 to −100 HU range. Neoplasms in the thorax with fatty components such as teratoma, thymolipoma, or the rare liposarcoma have a nonhomogeneous appearance and higher density readings.[8]

Computed tomography can detect in a relatively noninvasive way the vascularity of a lesion. The plan of treatment of a mediastinal mass can be altered dramatically by the CT findings (Figures 2A, B, & C). The inadvertent and hazardous biopsy of the wall of an aneurysm can be avoided by preliminary CT scanning.

Computed tomography has been used to diagnose a dissecting aortic aneurysm. In 16 patients with correlative angiograms, CT detected all 11 positive cases.[9] In another series, CT was judged equal or superior to aortography.[10] There are several pitfalls, however, in the CT diagnosis of aortic lesions. An aneurysm filled with clot may be mistaken for a solid avascular lesion, and highly vascular masses adjacent to a great vessel may appear to arise from it. A thrombosed false channel may resemble an aneurysm without dissection, a fractionated bolus of contrast may make the intimal flap difficult to visualize, and adjacent normal vessels or intimal calcifications may appear to be localized dissection.[11] Thin sections using a dynamic CT as described above can help to overcome these limitations. The precise relationship of an aneurysm to its parent vessel and the full extent of dissection is often better seen in the coronal, sagittal, or oblique plane. Computed images reconstructed in these planes or routine angiography in these projections may be necessary before surgical repair.

Computed tomography has been used to demonstrate the patency of coronary artery bypass grafts with an accuracy of 45-97% in several series.[12]

Vascular anomalies of the aortic arch, azygos system, and pulmonary arteries have been described by CT, and this technique can replace angiography in most cases.

Mediastinal masses with calcifications, masses containing air, and those causing rib and vertebral body erosion are better shown by CT than conventional tomography. Bronchogenic, enteric, and pericardial cysts usually contain water density material; however, occasional thick and viscous secretions within them may be as dense as solid neoplasms and difficult to distinguish from them.

Some suspected masses are best studied first by a non-CT method. A substernal thyroid may contain punctate calcification and its continuity with the inferior thyroid lobe can be demonstrated by CT. However, if iodinated contrast is used, the patient's iodide pool will be flooded and a radioiodide scan needlessly postponed for months.

Routine barium studies are suggested first in cases of suspected hiatal hernia or esophageal abnormality. Although extrinsic compression of the esophagus by a vascular ring, cyst, inflammatory, or neoplastic mass can be detected with CT, barium swallow and endoscopy are superior for mucosal detail.

Clinical syndromes associated with thymoma, such as myasthenia gravis and pure red cell aplasia,



Figures 2A & B — (Left) Aortic aneurysm. Forty-seven-year-old woman with progressive hoarseness and paralyzed left vocal cord on laryngoscopy had a mass on chest film (A) between aortic arch and left main pulmonary artery. Preliminary diagnosis was bronchogenic carcinoma. CT was requested to determine the extent of the mass and locate nodes for biopsy. (Right) At a level 2 cm below the aortic arch after intravenous contrast, an aneurysm with mural thrombus (arrows) is seen arising from the proximal descending aorta (A).

can be controlled in some cases by surgical excision of the lesion. Chest roentgenogram and conventional tomograms are often unable to detect this tumor until it is very large. Computed tomography is the recommended first test when the chest radiograph is normal or only questionably abnormal in patients with myasthenia gravis.[13]

Parathyroid adenoma is not well localized by barium swallow or radioisotope scan, and ultrasound cannot easily detect adenomas in ectopic sites. Computed tomography is less sensitive than selective arteriography but more accurate in localizing an adenoma then venous sampling.[14] Preliminary CT screening has been shown to be helpful to direct the surgical exploration in 7 of 14 patients with primary hyperparathyroidism.[15]

Computed tomography is particularly useful in clarifying questionable radiographic findings. The superior mediastinum is a difficult region to evaluate by conventional studies because of a paucity of air/soft tissue interfaces, a variable amount of fat deposition, and tortuous great vessels. In 71 cases of superior mediastinal widening, CT offered a definitive diagnosis in 92%. This information eliminated the need for a more invasive test in 58% of patients.[16] In the hilum, CT has been judged equal or superior to 55 degree oblique hilar tomograms in two series.[5, 17] For pericardial disease, CT has been able to better identify and characterize effusions and neoplasms than echocardiography.[18] In many areas, the classic roentgenographic signs are more readily visualized and understood using the transverse plane of CT.

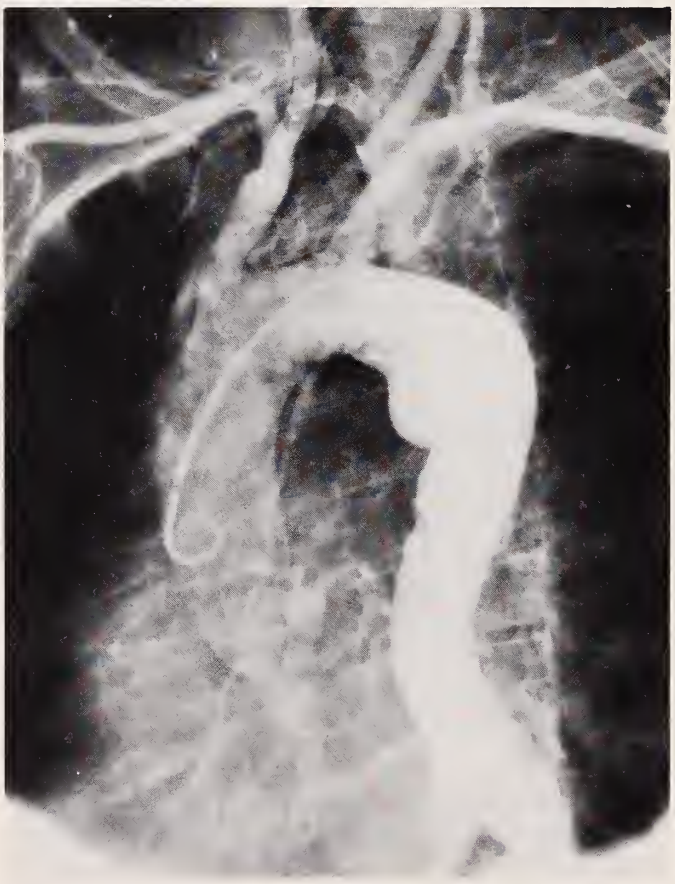


Figure 2C — Aortic aneurysm revealed in Figures 2A & B confirmed angiographically.

Neoplasms

The uses and limitations of CT in staging primary and secondary neoplasms of the chest are currently under investigation.

Computed tomography can be recommended as a routine screening exam in patients with documented carcinoma of the esophagus. Computed tomography can detect the presence of an intraluminal mass and esophageal wall thickening or the more advanced cases with spread into the contiguous soft tissues or distant sites. In 52 patients, CT results correlated with surgical findings in all 17 cases who had surgery and were crucial in the remaining 32 of 35 to whom radiotherapy was given.[19]

Computed tomography is more sensitive in detecting pulmonary nodules than the chest radiograph or conventional tomograms. In one series of 54 surgically resected nodules in patients with peripheral sarcoma or melanoma, 59% were detected by the conventional study and 78% by CT.[20] Computed tomography can detect nodules near the pleural margin, in the lung apices, behind ribs and hilar structures, along the diaphragmatic gutters, and other "blind" areas. Unfortunately, 60% of the additional nodules seen by CT proved to be granulomas or pleural based lymph nodes. Therefore, a positive CT scan requires further evaluation before radical surgery is denied. Although needle or open biopsy of the newly discovered nodules will provide a definitive diagnosis, research is in progress to characterize the pulmonary nodule in a noninvasive way.

Using the density information provided by CT, several groups have tried to determine the nature of the pulmonary nodule by detecting occult calcification. In the largest series to date, CT classified 33 of 91 apparently noncalcified solitary nodules as benign on the basis of their average Hounsfield values. The benignity was proved by biopsy or by failure to change in size on serial radiographs. No lung primary or metastatic lesion had a density reading in the benign range.[21] While the approach is philosophically sound, the results from this technique have not been uniformly positive. In another series, all but one of 22 benign nodules could be diagnosed on the basis of conventional tomograms alone.[22] This discrepancy may be due to a different distribution of granulomatous disease in various segments of the population, technical differences in the scanners used, or the quality and confidence in interpretation of the conventional studies.

In patients with lung cancer, the presence of tumor in mediastinal lymph nodes precludes surgical cure in most cases. Most authorities consider lymph nodes larger than 1.5 cm to be abnormal and those less than 1.0 cm normal, with the intermediate range regarded as suspicious. Lymph nodes in the retrocrural or internal mammary chains are considered abnormal at a lower threshold. Although CT is more sensitive than conventional exams for the detection of lymphadenopathy, it cannot distinguish inflammatory from metastatic disease. Small nodes replaced by tumor and enlarged nodes with reactive disease are the limitations of this technique. The frequency of these false-negative and false-positive findings in several biopsy proven series varies from 5% to 40%.[17, 23, 24] Therefore, CT is useful to locate abnormal nodal groups for biopsy by mediastinoscopy or thoracotomy or for planning radiation therapy.

In a recent study, 98 patients with lung cancer of all histologic types had prospective CT staging followed by surgical staging. By evaluating lymphadenopathy as well as mediastinal, pleural, or chest wall invasion, CT correctly classified 33 of 35 patients as resectable (94%) and 41 of 45 patients as unresectable for cure (91%). No opinion was given in the remaining 18 patients with inconclusive CT findings of intermediate size lymph nodes, neoplasm abutting but not invading the mediastinum or pleura, pleural or pericardial thickening, or uncalcified pulmonary nodules.[25] By extending the scan into the upper abdomen, CT can evaluate metastases to the liver and adrenal glands.[26]

On a statistical basis, the majority of patients with lung cancer can be staged successfully by CT. In the individual patient with no evidence or only questionable evidence of metastasis on the radiograph, the role of CT is to direct the radiologist or clinician toward biopsy of a suspect area in the lung, mediastinum, or abdomen.

Miscellaneous

Computed tomography can resolve the components of complex pleuroparenchymal shadows. In 37% of 46 scans done specifically for this reason, CT results were clinically useful.[27] It can potentially differentiate a pleural or pulmonary mass from an overlying effusion. In 70 cases, it has been successful in distinguishing empyema from pulmonary abscess.[28]

The normal CT anatomy of the bronchi has been described.[29] The CT signs of bronchiectasis in six patients with corroborating bronchograms have been defined.[30] A current new prospect for CT is the detection of bronchiectasis without the aid of bronchography.

In trauma, CT is a sensitive technique and revealed 50 lesions in 20 patients with chest trauma as compared to 12 by routine methods. Few of the CT findings were clinically significant, however.[31]

The CT density of normal lung can be computed.[32] Unlike conventional radiography, CT changes from emphysema and interstitial disease can be quantified. The method at present is no more sensitive than pulmonary function tests.

New lesions detected by CT and not visible by plain film or fluoroscopy have had successful CT-guided aspiration biopsy.[33]

Summary

Chest CT requires state of the art equipment with fast scanning time and thin collimation as well as a cooperative patient. It has become a valuable technique in the mediastinum and hilum, replacing conventional tomograms and angiography in many cases. It is recommended in staging carcinoma of the esophagus and has potential benefit in directing the staging of patients with lung carcinoma and other primaries. Because of its expense, consultation with a person experienced in chest CT is recommended before requesting this examination.

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This case report is used to review various parameters of this type of carcinoma such as etiology, symptoms, signs, staging, and treatment.

Primary Extratesticular Choriocarcinoma: A Case Report

WILLIAM T. NEUMANN, M.D., and NANCY W. STEAD, M.D., *Augusta**

GERM CELL CARCINOMA is the most common solid tumor in men ages 25-34 years; primary extragonadal germ cell tumors account for only 1-2% of these neoplasms.[1, 2] Two-thirds of all germ cell malignancies are nonseminomas; 10-20% of extragonadal primaries are found to be pure choriocarcinoma.[3-6] Multiagent chemotherapy with adjunctive surgery has improved the prognosis of metastatic nonseminomatous germ cell malignancy; 80% of patients achieve a complete remission, and 80% of these remissions will experience long-term, disease-free survival. For two reasons the prognosis of primary extragonadal choriocarcinoma remains grave. First, despite multimodality antineoplastic therapy, less than one third of patients with this histologic tumor type achieve complete remission.[2, 4, 7] Second, the literature suggests that primary extragonadal germ cell malignancies are less responsive to present day multimodality multiagent therapy than are their counterparts with a testicular primary;[4, 7] the series of Hainsworth et al.[2] is the only exception.

The majority of primary extragonadal germ cell tumors arise in the mediastinum or retroperitoneum;[5] however, other midline sites such as the stomach, duodenum, bladder, prostate, pineal gland, diencephalon, and presacrum have been documented in case reports.[4-6 8, 9] This paper details the clinical course of a young man with choriocarcinoma arising in the retroperitoneum and relates his case to those described in the literature.

* Drs. Neumann and Stead are from the Department of Medicine, Medical College of Georgia, Augusta, GA 30912. Send reprint requests to Dr. Neumann.

Case Report

The patient was a 22-year-old logger who presented with a 5-week history of an epigastric mass associated with a constant dull, aching pain in the abdomen and back, anorexia, and a 15-pound weight loss. He described intermittent melena for the week prior to admission. There was no history of cryptorchism. The family history was positive for hepatic carcinoma in his paternal grandfather. Physical examination revealed an apparently healthy white man in no distress. His skin was blemished with an acneform rash on the face and trunk both anteriorly and posteriorly. Palpable adenopathy in the superficial node-bearing areas was limited to a 1 centimeter mobile mass in the left supraclavicular fossa. Chest examination revealed bilateral gynecomastia. The heart and lungs were normal. In the epigastrium, there was an 8 centimeter mass which appeared pulsatile when the patient was supine, but not when he was sitting; no bruit was heard. The remainder of the physical examination was normal including guaiac negative stool, clinically normal testes, and normal neurologic function.

Laboratory data included a hemoglobin of 13.9 gm%, hematocrit of 41%, white blood cell count of 10,000/mm^3, and platelets numbering 510,000/mm^3. Prothrombin time and partial thromboplastin time were both normal. Liver function tests included elevated alkaline phosphatase of 136 IU/ml, lactic dehydrogenase of 503 U/ml and serum glutamic pyruvic transaminase of 74 U/ml. Beta human chorionic gonadotropin (βHCG) was 18,026 mIU/ml. Chest x-ray showed soft tissue densities, 1-4 centimeters in diameter, in both the left and right hemithoracies. Abdominal ultrasound examination showed in the head and mid portion of the pancreas a

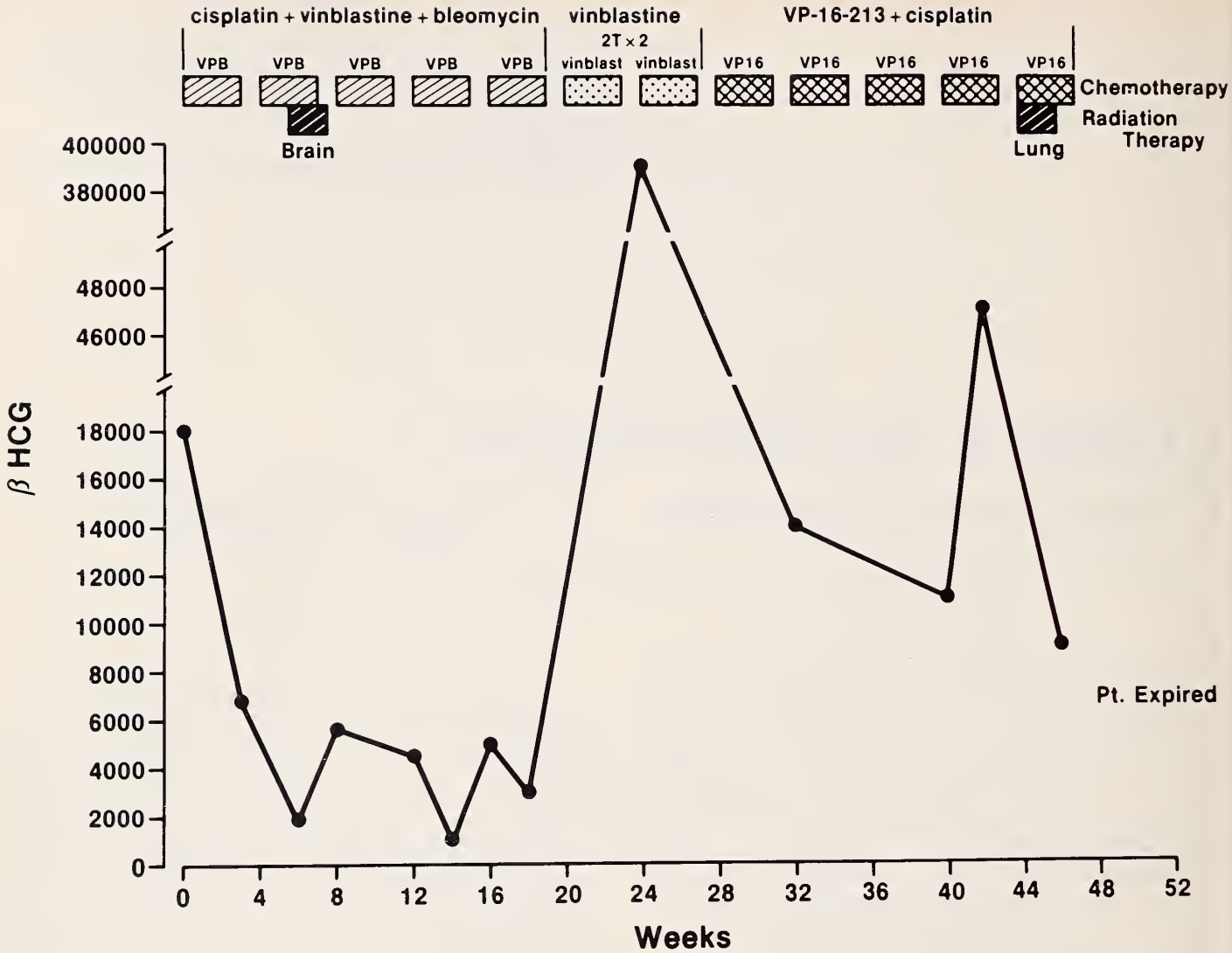


Figure 1 — The serum level of the patient's beta human chorionic gonadotropin (βHCG) in mIU/ml is shown on the ordinate and the week of therapy on the abscissa. The timing and type of antineoplastic therapy is shown by shaded blocks.

cystic mass which also encroached on the inferior vena cava.

At laparotomy, the patient was found to have both a large cystic, centrally necrotic mass which appeared to involve the body of the pancreas and multiple nodules on the surface of the liver. Histologically, both the hepatic lesions and the retroperitoneal mass were an undifferentiated carcinoma composed of syncytial trophoblastic and cytotrophoblastic cell types consistent with choriocarcinoma.

The patient was started on multiagent chemotherapy 2 weeks post-operatively (Figure 1). The regimen included cisplatin, vinblastine, and bleomycin (VPB) on a 3-week cyclic schedule as per Einhorn and Donohue.[10] The patient had five courses of this therapy each cycle of which consisted of cisplatin 20 mg/m^2 intravenously with mannitol diuresis on days 1-5, vinblastine 0.15 mg/kg IV on day 1 and 2, and bleomycin 30 units intravenously or intramuscularly on days 2, 9, and 16. The toxicities were insufficient to delay therapy.

During the initial course of chemotherapy the patient had onset of headache. Funduscopic examination remained normal, and no focal neurologic deficits were detected; however, a CT scan of the brain demonstrated bilateral intracranial metastases, one in the right parieto-occipital region and the other in the left occipital region. Systemic VPB therapy was continued; dexamethasone 16 mg a day was initiated and 3000 rads whole brain radiation was administered in 10 fractions. Cranial CT scan performed 1 month after completion of radiation revealed marked reduction of the lesion. An additional 2000 rads of radiation was administered to the known tumor masses and dexamethasone was tapered. A third CT scan of the brain showed complete resolution of the right hemispheric lesion with persistence of the small focus in the left occipital lobe.

The response of the patient's systemic disease to VPB therapy was assessed by monitoring the size of known tumor masses and by serum βHCG level. The size of the abdominal mass decreased progressively as documented by physical examination;

abdominal CT scan after 5 courses of VPB therapy showed complete resolution. The supraclavicular adenopathy ceased to be palpable after the fifth course of chemotherapy. In contrast to these two measures of disease, the pulmonary nodules which initially appeared to respond to chemotherapy began to increase in size 3 weeks after the fifth course of VPB. Figure 1 details sequential serum levels of βHCG. The level of βHCG never normalized but reached minimal levels approximately 2 weeks into each cycle of systemic chemotherapy and began to rise again before initiation of the subsequent cycle. Plasma level of the tumor marker increased greater than a hundredfold concurrent with enlargement of the pulmonary nodules. Thus, the patient failed to achieve a complete remission of known disease on VPB therapy.

He received two doses of vinblastine 0.15 mg/kg, and when clinical relapse occurred he was started on "salvage therapy" with VP-16-213 (VP 16) and cisplatin according to Williams et al.[11] Each 3-week cycle of medication included VP-16-213 100 mg/m^2 intravenously days 1-5 and cisplatin 20 mg/m^2 intravenously with mannitol days 1-5. Despite receiving 5 courses of this regimen, the patient experienced progressive pulmonary disease with enlargement of the metastatic lesions. Because of pleuritic pain, radiation (3000 rads in 2 weeks) was administered to the largest lesions which were in the right middle lobe and the left lower lobe. The pulmonary lesions diminished, and the βHCG titer fell. One month following completion of the above therapy, the patient presented with acute respiratory failure with bilateral interstitial infiltrates unresponsive to antibiotics and steroids. He died shortly thereafter. No post mortem was granted.

Discussion

Recently, there have been reports suggesting that the frequency of germ cell tumors is increasing. Certain epidemiologic risk factors have been defined. These are: higher socioeconomic class, age less than 35 years, caucasian race, native born rather than foreign born people, residence in a small community, and married as opposed to single men.[5, 12, 13]

Patients with choriocarcinoma will often present to the physician with an abdominal mass, hemorrhage and cough from pulmonary nodules, gynecomastia secondary to human chorionic gonadotropin, or headache and seizures from cranial metastases. Pulmonary nodules are as commonly the cause of symptoms bringing the patient to a physician as is an abdominal mass. Review of systems may uncover constitutional symptoms of weight loss and anorexia despite the healthy appearance of the patient. Gynecomastia is present on physical examination in 50% of the patients.[5, 8, 9] Multiple pulmonary nodules in a man with gynecomastia are virtually diagnostic of choriocarcinoma.[8] Although our patient was aware of an epigastric mass, initial medical evaluation disclosed in addition both gynecomastia and pulmonary nodules.

Not only is the tumor marker βHCG reliable for diagnostic purposes as it was initially used in this case, but βHCG titre may also serve as a reliable measure of the success of therapy or recurrence of tumor as it was employed in this particular case. Patients with choriocarcinoma always shed βHCG, and a sustained or rising titre always accompanies persistent or recurrent tumor.[14] Reduction in titre βHCG after VPB chemotherapy correlated very well in this patient with reduction in size (but not resolution) of pulmonary disease. As his tumor became refractory to treatment, the rise in βHCG paralleled the concomitant advancement of pulmonary parenchymal disease.

Patients with choriocarcinoma always shed βHCG, and a sustained or rising titer always accompanies persistent or recurrent tumor.

Germ cell neoplasms can occur with or without testicular primary lesions. The pathogenesis of the origin of extragonadal germ cell malignancy has evolved from that of Prym[15] which was supported by Rather.[16] Both of these authors proposed that the origin of extragonadal germ cell neoplasms lay in a small testicular primary which had regressed by the time the patient sought medical care; they advocated orchiectomy. Today, the origin of primary extragonadal germ cell malignancies is explained by one of several theories: 1) totipotential cells remaining from embryonic life in the morula or blastula stage of development which undergo malignant degeneration; 2) a dormant trophoblastic embolus acquired in fetal life which undergoes malignant degeneration; 3) metaplasia and dedifferentiation of a carcinoma originally not of germ cell origin; or 4) neoplastic transformation of germ cells that have become displaced at various points along the urogenital ridge. None of these explanations invokes a primary testicular lesion as the source of what appears clinically to be only extragonadal germ cell tumor. These explanations are invoked because the literature includes case descriptions in which serial sectioning of clinically normal testes fail to reveal a testicular primary or a testicular scar.[4, 6, 8] Thus, orchiectomy is not part of current day management of primary extragonadal germ cell malignancies, and this procedure was not performed on the patient under discussion.

The histologic criteria for the diagnosis of cho-

riocarcinoma do not depend on the site of the primary tumor. However, clinical staging of the extent of disease is influenced by the site of the primary tumor. In contrast to the testicular counterpart, extragonadal germ cell malignancies are a sufficiently rare subgroup of germ cell tumors that no unified staging system has evolved. Possibly such a system would not be useful, because primary extragonadal germ cell tumors are usually bulky with clinical metastases beyond the paraaortic abdominal nodes at the time of presentation. Germ cell neoplasms with testicular primaries are staged A (localized to testis), B (localized to testis and paraaortic nodes), and C (beyond those two sites). Samuels et al.[17, 18] demonstrated that patients with bulky (5 centimeters or greater) disease had a poorer prognosis than those with smaller tumor masses. When Hainsworth et al.[2] staged 32 patients with primary extragonadal germ cell tumors by the criteria of Samuels et al., 31 out of 32 had advanced disease at the time of presentation. The patient in this report also presented with advanced disease.

The inability to effect complete resolution of known disease and the short duration of a partial response is the rule rather than the exception.

With only the surgical and radiotherapeutic modes of treatment, testicular choriocarcinoma is almost always fatal. Chemotherapy has improved the prognosis. Methotrexate or chlorambucil — either of which is successful in the treatment of gestational choriocarcinoma — are not effective beyond this setting. Combination chemotherapy with chlorambucil, methotrexate, and actinomycin-D effected a 50% combined complete and partial response rate in 28 patients with testicular nonseminomatous germ cell neoplasms; one of these patients who had a complete remission had choriocarcinoma. However, despite initial response to these drugs, only 5-10% of patients who began therapy remained in remission 2 years after cessation of all treatment.[19] Current regimens combine vinblastine, bleomycin, and cisplatin with or without additional drugs; therapy with these three agents can effect an objective response in more than 90% of patients with nonseminomatous germ cell malignancy, but only 60-65% of patients achieve complete resolution of all demonstrable disease; adjunctive surgery will increase the percentage of complete responders to 80%.[2, 10] Complete response of choriocarcinoma to antineoplastic therapy means disappearance of all measurable tumors and normalization of βHCG. Such a complete response is necessary for long-term survival; actuarial survival suggests that as many as 80% of patients with a complete response of all known tumor will remain disease free off chemotherapy for more than 2 years. A partial response is a decrease in tumor size of at least 50%; nonetheless, median survival is only 9 months. Choriocarcinoma is the tissue type least likely to achieve complete remission; when chemotherapy with vinblastine, bleomycin, and cisplatin was given to seven patients with extragonadal choriocarcinoma, only two or 29% had complete resolution of both measurable disease and elevated tumor marker.[2] Thus, the inability to effect complete resolution of known disease as in this case report is not unexpected, and short duration of a partial response as seen in this case is the rule rather than the exception.

As many as 30% of men with nonseminomatous germ cell malignancies may benefit from multiagent therapy beyond the combinations including vinblastine, bleomycin, and cisplatin. Drugs currently being studied in Phase II trials include vindesine, a vinca alkaloid, or VP-16-213, an epipodophyllotoxin, employed alone or in combination with adriamycin, cisplatin, and/or bleomycin. VP-16-213 with its combinations was described in a series of patients by Williams et al.[11]; only partial remission was achieved in the two patients with extragonadal choriocarcinoma who had previously failed therapy with VPB.

Cranial metastases are not an uncommon complication of testicular malignancies; they have been described in as many as 37% of such patients.[20, 21] The symptomatology is often protean, and headache as occurred in our patient is the most common complaint; it occurs in 50% of men with cranial metastases. These lesions are not very susceptible to treatment by systemic chemotherapy, because the blood brain barrier prevents accumulation of cytotoxic levels of drugs in the brain and spinal fluid; thus, development of symptomatic cranial metastases during otherwise successful systemic chemotherapy does not indicate drug resistance. The management which our patient received — that is, dexamethasone to reduce intracranial pressure and cranial radiation while continuing therapy for his systemic disease with drugs — is the usual form of management.

Summary

Multimodality therapy of today offers some hope to the patient with extratesticular choriocarcinoma. The preceding case is used to review various parameters such as etiology, symptoms, signs, staging, and treatment of extratesticular choriocarcinoma.

Acknowledgements

The authors which to acknowledge discussions with Dr. Tom Poskit of East Tennessee State University and the valuable assistance of Mrs. Mary Brockman in the preparation of this manuscript.

(References listed on page 111.)

The saga of an intricate hobby: building miniature engines for recreation and relaxation.

Off Hours: The Doctor Is an Engineer

EVELYN WARD GAY, ***Decatur****

WHEN HE IS NOT treating patients, Dr. J. Donald Fite of DeKalb County is playing with small gauge steam engines. He not only builds locomotives from scratch and acts as an engineer in full regalia, he finds free time occasionally to use his hobby to bring help and enjoyment to other people.

Recently, his steam engine was placed on a portable track, and rides were offered to children to raise funds for the Georgia Society for the Prevention of Blindness. The money was used to help buy a "vision van" which was taken throughout the state to screen people's eyes to detect such problems as glaucoma.

Last year, an Octoberfest was held at Perimeter Center with donations from train rides going to the Georgia Diabetes Association. Free rides also are given regularly to "children 1½ to 80 years of age" at church picnics. The train is run on an oval, 300-foot track which Dr. Fite and his son built by bolting together conveniently separated sections. Each rider gets about three trips around the track. Dr. Fite operates the engine and often tells the riders about locomotives and how they function. At one such recent event, about 800 people enjoyed rides.

Dr. Fite says he has always been interested in building things. He and his twin brother, David Fite, now a professor at the Southwest Theological Seminary in Fort Worth, Texas, began building model airplanes when they were children and progressed to full-size motor boats. Dr. Fite was drawn to metal-working tools and began to look around for something big to build. In his search, he used another of his hobbies — reading — and the steam locomotive caught his eye. He became fascinated by its usefulness to the country in pioneer America.



Photo courtesy of Col. James Bogle

Decatur ophthalmologist, J. Donald Fite, stands next to the coal-burning locomotive he built as a hobby.

"The steam locomotive was a unique and prime mover in our country's past," he declares. "Building and maintaining those trains in a primitive society was important in the development of the nation. They were very effective for a time, and although steam locomotives are no longer means of pulling trains, they have left us a colorful history."

Even a miniature train engine has its own personality, he claims. "It wheezes, makes noises, and comes alive. Anyone who has worked on one regards it with warm affection," he says.

Dr. Fite had never thought of doing anything like building a real steam engine, but he began to gather a library on machinery and to collect electric-powered

* Mrs. Gay is Chairman of the Research and Romance of Medicine Committee of the Auxiliary of the MAG. Her address is 911 Vistavia Circle, Decatur, GA 30033.

tools for his basement workshop. The Fites soon began going to meetings with other people who were interested in the same hobby. The Mid-South Live Steam Club, headquartered in Columbia, Tennessee, was the closest group available to them until a club was begun in Atlanta called the North Georgia Live Steam Club. The Tennessee club, located in Murray County, has a permanent track in a park where enthusiasts of this hobby gather periodically. One week-end recently, Dr. Fite says, there were 35 steam engines there to attract the attention of train lovers. The North Georgia Live Steam Club has about 15 members. There is also an International Brotherhood of Live Steamers, and a magazine called *Live Steam* which reaches all interested members is published in Michigan.

Weighing about 450 pounds, Dr. Fite's coal-burning engine is patterned after one which ran on the Wabash Line.

Dr. Fite explains that these clubs are loosely organized groups located in each geographic area, and the main object of their formation is to keep lists of interested people so that they can exchange notes, get together occasionally, and offer and receive advice from each other.

He started building his first steam locomotive about 9 years ago with the help of his son who was then about 9 years old. Since he could work only in his spare time, it took 5 years to complete. His locomotive measures 1½ inches to the foot of a regular-sized engine. It uses coal which he buys from a mine in Alabama. "It is a clean-burning, high grade coal," he says of the pile of several tons which he keeps on his back lot. His engine uses about 1 pound of coal per mile and costs about 40 cents a pound.

He was the first member of the local club to complete an engine of this size. Weighing about 450 pounds, his engine is patterned after one which ran on the Wabash Line. Built in 1899, that locomotive ran until 1954 when it was retired and placed in a museum.

Dr. Fite usually works with the Western Electric Company's Pioneer Club, a service organization, when he gives rides to children to raise money, but he is also well known in his own neighborhood for his generosity in offering his train engine for entertainment purposes. On one wall of his office hangs a model locomotive complete with steam issuing from the engine and mounted on a red board. It was made by students at Avondale Elementary School in their arts and crafts class and presented to Dr. Fite in 1982 for "exemplary community service."

Last May, Dr. Fite and his wife Mary joined with other train lovers from around the world for a trip to Holland and France where they visited several museums and exhibits. Called the "very first live steam tour of Europe," the trip took "20 pioneers" on what was later termed "an unforgettable excursion." From the International Terminal at New York's Kennedy Airport, the Fites flew with a group of Americans to Amsterdam where they enjoyed a canal cruise and a sightseeing tour of the city before going on to Groningen over the Barrier Dam to visit the small town of Leek, site of the Nienoord Railway where the 10th annual Nienoord International Live Steam Meet was being held. Host for the event was Rob van Dort, secretary for the European region and one of the four senior engineers responsible for the operation of the Nienoord Railway. It is located in a city-owned park on the grounds of what was once a privately owned castle but is now a gourmet restaurant. A museum is also on the grounds, as well as a zoo, a playground, a lake for operating radio-controlled boats, and a "live steam track" through the beautiful woods. Thousands of visitors came during the 4 days of the meet, says Dr. Fite.

The Fites and their fellow Americans were treated to a dinner in the castle and an excursion on a steam locomotive from the town of Hoorn northwest through the tulip country to the town of Medemblik where they saw the Dutch countryside with its windmills and charming architecture.

Later, the group went to Paris by modern electric train, passing through the major Dutch cities of The Hague and Rotterdam, and Brussels, Belgium. In Paris they visited historic sites before going on to the small town of Pithiviers to tour a railway museum for French narrow gauge equipment of historic importance.

In September of 1983, the magazine *Live Steam* devoted a portion of that month's issue to the European trip, and the front cover showed Dr. Fite in his engineer's outfit.

Steaming History

The steam locomotive does indeed have an interesting history. The first suggestion that steam could move a vehicle had been made by Sir Isaac Newton in 1680. In 1801, Richard Trevithick, a Cornish mine captain, built the first one in the world which actually worked. George Stephenson, an Englishman, built an engine which he called "Blucher" in 1814, but it was not until some years later that he and his son, Robert Stephenson, improved his technique and produced the "Rocket," the first successful full-sized locomotive. At about that time, the director of the Liverpool and Manchester Railroad offered a prize of 500 pounds for the best locomotive engine. There were 10 entries. Trials lasted 7 days and Stephenson's "Rocket" won the prize, traveling at a rate of 12½ miles per

hour when pulling a load 3 times its weight. With a carriage and passengers, it could make 24 miles per hour. The weight of the engine was about 9,500 pounds, and the cost per mile for fuel was 3 pence.

However, in the interim, the first public railway had been opened in 1825, and Stephenson was the engineer on a train called "The Locomotion" which he had built that year.

The modern hobby of building miniature engines also developed in England and soon spread around the world.

In 1829, the locomotive "America" furnished by Robert Stephenson's company arrived in New York, but it was never operated in the United States. During the same year, "The Stourbridge Lion" from Stourbridge, England, was the first to be run in the Western Hemisphere. It was operated out of Honesdale, Pennsylvania.

In the United States, an attempt was made to build a locomotive as early as 1829, but it was not until 1830 that the first regular commercial train service began with Horatio Allen's locomotive named "The Best Friend of Charleston." The "North Star" was the first engine to exceed 60 miles per hour, and this was not until 1837. In Georgia, trains began operating in the mid-1800s.

Personal Background

Dr. Fite was born in Texas while his father was in theology school. He has lived in several other places, including Oklahoma, but he considers Georgia his home. In spite of his interest in trains, he decided in high school that he wanted to be a doctor. His grandfather, Dr. Berry W. Fite, attended the old Southern Medical College in Atlanta and was graduated in 1899 from the school which eventually became the Emory University School of Medicine. Donald Fite has his grandfather's diary which gives insight into how expenses were recorded for his medical training before the turn of the century.

After graduating from Wake Forest College in North Carolina, Donald Fite returned to Georgia and received his medical degree in Augusta at the Medical College of Georgia, later completing his training in ophthalmology at Emory University and Grady Memorial Hospital. He was on the faculty of the medical school at Emory for 1½ years and has been in the practice of ophthalmology in Decatur since 1967.

Dr. Fite does not find it strange that he should become interested in using his hands to build intricate machinery. Many of the ophthalmologists he knows have similar hobbies, he says. Some carve objects from various materials, turning out such things as beautiful pieces of jewelry. He believes that performing delicate eye surgery is itself a form of art.

The Fites are active in the First Baptist Church of Avondale Estates. He serves on the Board of Deacons and teaches a Sunday School class of young married couples, while Mrs. Fite, a part-time psychiatric nurse at DeKalb General Hospital, has done work in the nursery. They have two children, a daughter who is a legal secretary, and a son who is a steamfitter in Norcross.

Dr. Fite is a member of the DeKalb County Medical Society, the Medical Association of Georgia, the American Academy of Ophthalmologists, and the International Society of Neuro-Ophthalmologists. In 1970, he spent 2 months in Jamaica where he worked aboard the hospital ship Hope. When he has time, he "plays a little golf," he says, and is interested in growing orchids. In the meantime, he is busy working on his second live steam locomotive.

New Drug Under Investigation at Emory for Treatment of Depression

Research is underway at Emory University's Department of Psychiatry on a new drug for the treatment of melancholic depression. The drug under investigation is adinazolam which is a member of a "new generation" of benzodiazepines called triazolobenzodiazepines. These drugs contain a cyclic structure similar to the tricyclic antidepressants which suggest they may have specific antidepressant activity. A similar drug, alprazolam (Xanax) was recently found to be as effective as the tricyclic imipramine in a large multicenter randomized clinical trial. The advantage of the triazolobenzodiazepines lies in the fact that they may be more effective for the anxiety and agitation that accompany most major depressions. In addition, they tend to be devoid of anticholinergic side effects that usually accompany tricyclic antidepressants. This class of agents may be particularly helpful in treating elderly patients who are vulnerable to the anticholinergic and hypotensive effects of the tricyclics. Physicians wishing to refer patients for evaluation for this study may contact Dr. Alan Stoudemire at Emory University Clinic, 321-0111, ext.3297.



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Warnings: Do not use potassium supplements, dietary or otherwise, unless hypokalemia develops or dietary intake of potassium is markedly impaired. If supplementary potassium is needed, potassium tablets should not be used. Hyperkalemia can occur, and has been associated with cardiac irregularities. It is more likely in the severely ill, with urine volume less than one liter/day, the elderly and diabetics with suspected or confirmed renal insufficiency. Periodically, serum K^+ levels should be determined. If hyperkalemia develops, substitute a thiazide alone, restrict K^+ intake. **Associated widened QRS complex or arrhythmia requires prompt additional therapy.** Thiazides cross the placental barrier and appear in cord blood. Use in pregnancy requires weighing anticipated benefits against possible hazards, including fetal or neonatal jaundice, thrombocytopenia, other adverse reactions seen in adults. Thiazides appear and triamterene may appear in breast milk. If their use is essential, the patient should stop nursing. Adequate information on use in children is not available. Sensitivity reactions may occur in patients with or without a history of allergy or bronchial asthma. Possible exacerbation or activation of systemic lupus erythematosus has been reported with thiazide diuretics.

Precautions: Do periodic serum electrolyte determinations (particularly important in patients vomiting excessively or receiving parenteral fluids, and during concurrent use with amphotericin B or corticosteroids or corticotropin [ACTH]). Periodic BUN and serum creatinine determinations should be made, especially in the elderly, diabetics or those with suspected or confirmed renal insufficiency. Cumulative effects of the drug may develop in patients with impaired renal function. Thiazides should be used with caution in patients with impaired hepatic function. They can precipitate coma in patients with severe liver disease. Observe regularly for possible blood dyscrasias, liver damage, other idiosyncratic reactions. Blood dyscrasias have been reported in patients receiving triamterene, and leukopenia, thrombocytopenia, agranulocytosis, and aplastic and hemolytic anemia have been reported with thiazides. Thiazides may cause manifestation of latent diabetes mellitus. The effects of oral anticoagulants may be decreased when used concurrently with hydrochlorothiazide; dosage adjustments may be necessary. Clinically insignificant reductions in arterial responsiveness to norepinephrine have been reported. Thiazides have also been shown to increase the paralyzing effect of nondepolarizing muscle relaxants such as tubocurarine. Triamterene is a weak folic acid antagonist. Do periodic blood studies in cirrhotics with splenomegaly. Antihypertensive effects may be enhanced in post-sympathectomy patients. Use cautiously in surgical patients. Triamterene has been found in renal stones in association with the other usual calculus components. Therefore, 'Dyazide' should be used with caution in patients with histories of stone formation. A few occurrences of acute renal failure have been reported in patients on 'Dyazide' when treated with indomethacin. Therefore, caution is advised in administering nonsteroidal anti-inflammatory agents with 'Dyazide'. The following may occur: transient elevated BUN or creatinine or both, hyperglycemia and glycosuria (diabetic insulin requirements may be altered), hyperuricemia and gout, digitalis intoxication (in hypokalemia), decreasing alkali reserve with possible metabolic acidosis. 'Dyazide' interferes with fluorescent measurement of quinidine. Hypokalemia is uncommon with 'Dyazide', but should it develop, corrective measures should be taken such as potassium supplementation or increased dietary intake of potassium-rich foods. Corrective measures should be instituted cautiously and serum potassium levels determined. Discontinue corrective measures and 'Dyazide' should laboratory values reveal elevated serum potassium. Chloride deficit may occur as well as dilutional hyponatremia. Concurrent use with chlorpropamide may increase the risk of severe hyponatremia. Serum PBI levels may decrease without signs of thyroid disturbance. Calcium excretion is decreased by thiazides. 'Dyazide' should be withdrawn before conducting tests for parathyroid function.

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The sociodemographics of women obtaining abortions in 1980 were relatively unchanged from previous years, while a true decline (not a statistical artifact) in the number of abortions was recorded.

Legal Abortion in Georgia, 1980

ALISON M. SPITZ, M.P.H., MARK OBERLE, M.D., M.P.H., and SUSAN M. ZARO, M.P.H., *Atlanta**

Abstract

Georgia legalized induced abortion in 1968, and until 1980, the number of abortion procedures reported to the Department of Human Resources increased each year. However, in 1980, the reported number of induced abortions decreased 9 percent from the number reported in 1979. The abortion rate and ratio for residents declined in 1980, a lower percentage of residents obtained repeat abortions, and a higher percentage of residents obtained abortions during the first 12 weeks of gestation. In 1980, the survey of abortion providers conducted by the Alan Guttmacher Institute also reported the number of abortions performed in Georgia had decreased (by 2 percent) between 1979 and 1980.

Introduction

In 1980, the Georgia Department of Human Resources (DHR) reported a decrease in the number of induced abortions as compared with the number reported in 1979. This decrease marked the first time since 1968 (when Georgia legalized abortion) that the number of abortions reported had not increased from year to year.[1] To verify this reported decrease, we compared the number of abortions reported to the DHR with the number reported in a survey conducted by the Alan Guttmacher Institute (AGI).[2] We also described the characteristics of women obtaining abortions in Georgia in 1980. We found a decrease in the percentage of residents obtaining repeat abortions and an increase in the percentage of residents obtaining abortions in the first 12 weeks of gestation.

Background

From 1968 to 1973, the State of Georgia permitted induced abortion in limited situations only (e.g., to save a woman's life). Since the 1973 Supreme Court decision, the State has permitted unrestricted first-trimester abortions, although medical institutions and their staff are not required to provide abortion services.[3] Like other state legislatures, the Georgia legislature has passed laws regulating abortion services provided after the first trimester of pregnancy.[4] These laws state that (1) abortions performed after the first trimester must be done in a licensed general or limited-services hospital; (2) third-trimester abortions must be performed only to save the life or health of a woman and that they must be authorized by the attending physician and two consulting physicians; and (3) medical care must be provided to a fetus surviving an abortion procedure.

From February through September 1980, the Georgia Medicaid program funded abortions of low-income Georgia women. However, during the remainder of the year, the Medicaid program, following the Hyde Amendment, funded abortions in only two situations: (1) to save a woman's life or health, and (2) to terminate pregnancies resulting from rape or incest.[5]

Methods

The DHR defines induced abortion as the procedure by which pregnancy is purposely terminated in order to avert a live birth.[4] To determine the characteristics of women having abortions in Georgia each year, the DHR requires physicians to report all abortions on a standardized form within 10 days of the event. These abortion data are used to monitor pat-

* Ms. Spitz is Epidemic Intelligence Service Officer, Division of Reproductive Health (DRH), Centers for Disease Control (CDC), assigned to Family Planning Program, Georgia Department of Human Resources; Dr. Oberle is Medical Epidemiologist, Program Evaluation Branch, DRH, CDC; and Ms. Zaro is Program Manager, Epidemiologic Studies Unit, Georgia DHR. Send reprint requests to Ms. Spitz, Division of Reproductive Health, Centers for Disease Control, Atlanta, GA 30333.

terns of abortion use and as an indicator of unintended pregnancy.

In addition to the DHR, there is another source of abortion data for Georgia — the AGI.[6] On the basis of a yearly survey of all known abortion providers, the AGI estimates the number of abortions performed in each state. Abortion providers supply the AGI with an aggregate number of estimated abortions obtained at their facilities rather than the individual abortion reports sent to the DHR.

We used Georgia abortion data obtained by both the DHR and the AGI for the following reason. Since AGI contacts providers directly, the total number of abortions reported for Georgia are generally higher and probably a more accurate reflection of the abortions performed compared to those reported to the DHR. However, the AGI does not collect information on the characteristics of women who have abortions while the DHR does gather that information.

The abortion rates and ratios used in our report were derived from these two data sources. We defined abortion rate as the number of abortions per 1,000 women aged 15-44 and abortion ratio as the number of abortions per 1,000 live births.

Number of Abortions

The number of abortions reported to the DHR declined from a high of 36,579 in 1979 to 33,288 in 1980, a 9 percent decrease (Table 1). In 1980, the AGI also reported the first decrease (2 percent) in the number of abortions reported for Georgia. The declining number of abortions was reflected in the abortion rate: in 1980, there were 23.9 abortions per 1,000 women aged 15-44 compared with 26.6 abortions per 1,000 women aged 15-44 in 1979. The long-term trend is shown in Figure 1.

Sociodemographic Characteristics

Residence

In 1980, Georgia residents obtained 90.7 percent of reported abortions performed in Georgia — an increase of 2.5 percentage points over 1979 (Table 2). This increase is consistent with a national trend toward an increasing proportion of abortions performed in a state being obtained by that state's residents.[7] In 1980, the number of abortions performed in Georgia declined 6 percent for residents of Georgia and 29 percent for out-of-state (OOS) women. As in the past, women from the adjacent states of Alabama, South Carolina, and Tennessee accounted for most of the abortions obtained by OOS women (80 percent). And again, most Georgia residents obtaining abortions in other states obtained them in Florida (67.9 percent) and Tennessee (19.5 percent) (personal communication: Centers for Disease Control and the AGI).

TABLE 1 — Induced Abortions[1] Reported to the Georgia Department of Human Resources (DHR)[2] and Reported to the Alan Guttmacher Institute (AGI)[3, 4] Georgia, 1974-1980

	Reported Abortions		
Year	*DHR*	*AGI*	*Ratio of Abortions Reported DHR : AGI*
1974	22,009	21,740	101.2
1975*	23,733	23,780	99.8
1976	25,680	25,820	99.4
1977	29,549	32,490	90.9
1978	34,878	36,080	96.7
1979	36,579	38,760	94.4
1980*	33,288	37,890	87.9

[1] Includes nonresident abortions.
[2] Source: Office of Health Planning and Statistics, Georgia Department of Human Resources, 1974-1980.
[3] Source: Abortion: Need, Services and Policies, Georgia. The Alan Guttmacher Institute, New York, 1979.
[4] Source: Henshaw SK, Forrest JD, Sullivan E, et al: Abortion 1977-1979: Need and Services in the United States, Each State and Metropolitan Area, the Alan Guttmacher Institute, New York, 1981.
* New reporting form introduced.

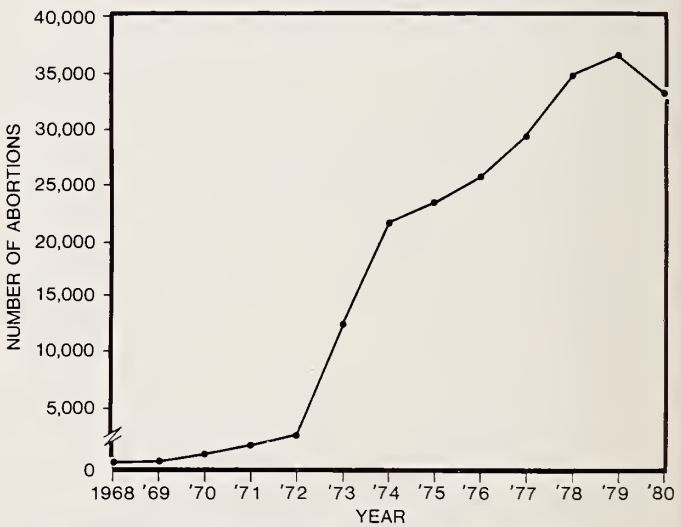


Figure 1 — Induced Abortions,[1] Georgia, 1968-1980[2]
[1] Includes abortions performed on nonresidents.
[2] Source: Office of Health Planning and Statistics, Georgia Department of Human Resources, 1968-1980

The abortion ratio for residents decreased in 1980 from 367.7 to 327.4 abortions per 1,000 live births. This is in contrast to national figures showing that the ratio increased slightly from 358.3 to 359.4 abortions per 1,000 live births.[7]

The abortion ratio for residents of Georgia counties ranged from 0 to 720 (Figure 2). Fulton County and DeKalb County still had the highest abortion ratios, 720 and 610, respectively. Consistent with a 1974 study of Georgia abortion patterns, utilization of abortion tended to decrease as distance from the Atlanta area increased.[8] However, from 1974 to 1980, the number of counties with abortion ratios of less than 75 decreased from 84 to 31. Most of these counties are located in south Georgia. In 1980, a total of 1,265 Georgia women obtained abortions in Florida, as compared with 1,355 in 1979.

TABLE 2 — Characteristics of Women Receiving Abortions, Percentage Distribution, Georgia, 1979 and 1980

Characteristics	*1979*	*1980*
Residence[1]		
Georgia Residents	88.2	90.7
Out-of-State Residents	11.8	9.2
Age		
≤19	30.6	29.9
20-24	33.5	34.8
≥25	33.4	35.3
Unknown	2.5	0.0
Race		
White	65.4	62.7
Black and All Other	34.9	36.6
Marital Status		
Married	24.3	24.4
Unmarried	75.7	74.8
Maternal Education		
≤11 years	21.0	19.7
12 years	44.0	43.2
≥12 years	30.8	32.7
Unknown	4.2	4.4
Number of Living Children		
0	60.3	58.0[2]
1	19.3	20.7
2	13.2	14.0
≥3	7.2	7.3
Previous Induced Abortions		
0	66.3[3]	71.3[4]
1	26.3	22.7
2	6.0	4.4
≥3	1.5	1.4

[1] Excluded < 1% unknown.
[2] "Unknown" (20%) distributed according to known distribution.
[3] "Unknown" (21%) distributed according to known distribution.
[4] "Unknown" (17.8%) distributed according to known distribution.

Most abortions obtained by Georgia residents were performed in one of two northwest Georgia counties — Fulton (72 percent) or adjoining DeKalb (7.5 percent). However, only 21.7 percent of Georgia women aged 15-44 reside in those counties. No other county contributed more than 5.5 percent of the total number of reported abortions. While the proportion of abortions performed in Fulton and DeKalb counties remains high, in 1974, a total of 90 percent of all abortions were performed in one of these two counties.[8]

Age

The age distribution of women obtaining abortions remained essentially the same in 1980 as it was in 1979 (Table 2). This distribution was almost identical with the national distribution.[7] Women aged 20-24 still had the highest abortion rate, 41 abortions per 1,000 women. In 1980, the abortion rate for residents decreased for all age groups except for women ≤ 14 years old and those ≥ 35 — the two age groups with the lowest rates, two and four abortions per 1,000 women, respectively.

The abortion ratio for residents also decreased for all age groups except for women ≤ 14 years of age.

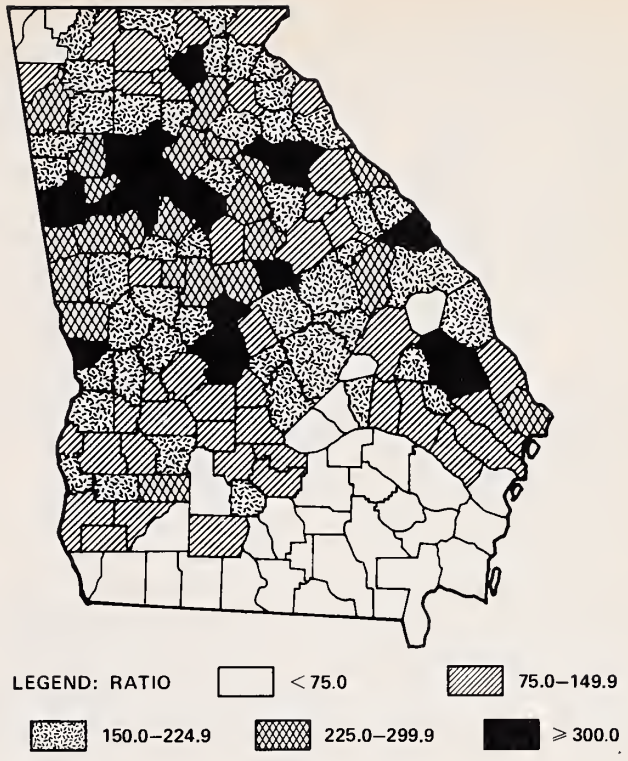


Figure 2 — Georgia Abortion Ratios[1] by County of Residence, 1980[2]
[1] Number of Abortions per 1,000 live births
[2] Source: Office of Health Planning and Statistics, Georgia Department of Human Resources, 1980

Race

White women obtained most reported abortions (63 percent). However, the proportion of abortions obtained by black women increased slightly in 1980 (Table 2). In contrast, nationally, the percentage of abortions obtained by black women decreased slightly.[7]

In 1980, the abortion ratios for both white and black women decreased — by 13 percent and 4 percent, respectively. The ratio for white women was 317 abortions per 1,000 live births, while the ratio for black women was 342 abortions per 1,000 live births.

Marital Status

In 1980, there was no change in the marital-status distribution of women who obtained abortions (Table 2). However, nationally, the proportion of unmarried women who obtained abortions increased slightly.[7] In Georgia, the abortion ratio for unmarried women was 13 times greater than that for married women — 1,166 abortions per 1,000 live births compared with 88 abortions per 1,000 live births.

Mother's Education

In 1980, as in previous years, more than two-thirds of women obtaining abortions had ≤ 12 years of education (Table 2). Among single women aged 10-19 and 20-44 years old, the percentages of preg-

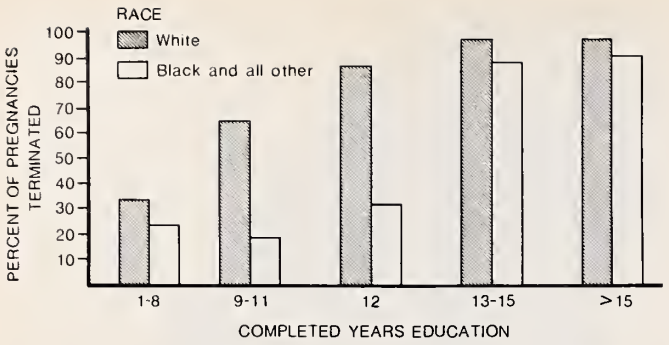


Figure 3A — Percentage of Reported Pregnancies Terminating in Induced Abortion Obtained by Single Women Aged 10-19, by Race and Educational Attainment, Georgia, 1980[1]

[1] Source: Office of Health Planning and Statistics, Georgia Department of Human Resources, 1980

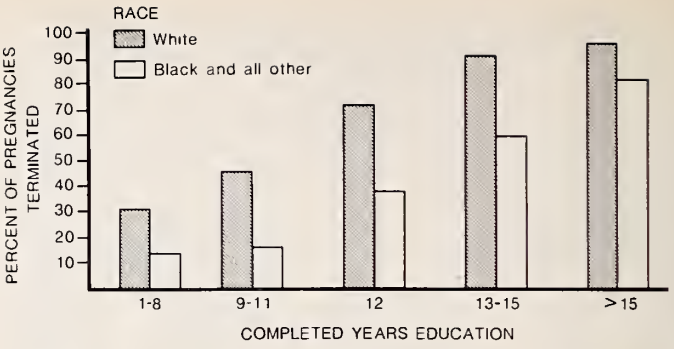


Figure 3B — Percentage of Reported Pregnancies Terminating in Induced Abortion Obtained by Single Women Aged 20-44, by Race and Educational Attainment, Georgia, 1980[1]

[1] Source: Office of Health Planning and Statistics, Georgia Department of Human Resources, 1980

nancies ending in induced abortion increased dramatically with level of education (Figures 3A and 3B). However, at each educational level a greater percentage of white women aged 10-19 and 20-44 years old terminated pregnancies by abortion compared with the percentage for black women.

Previous Induced Abortions

For 20 percent of women in 1979 and 21 percent of women in 1980, the number of previous induced abortions was unknown. We distributed the data for these women on the basis of the known distribution for women with previous abortions. The percentage of women who obtained repeat abortions decreased from 34 percent in 1979 to 29 percent in 1980 (Table 2). This reversed a statewide and national trend toward an increasing percentage of repeat abortions.[7]

Gestation, Type of Procedure, and Type of Facility

Weeks of Gestation

An increasing percentage of women obtaining abortions did so during the first 12 weeks of gestation (93 percent in 1980, compared with 89 percent in 1979) (Table 3). In 1980, the percentage of women who obtained abortions during the first 12 weeks of gestation was slightly higher than the national average (90 percent).[7] Abortions performed in Georgia after 20 weeks' gestation decreased from 4 percent of all abortions to 2 percent in 1980.

Type of Procedures

Almost all procedures were curettage (Table 3). However, the type of procedure varied according to the stage of gestation at which the abortion was performed (Table 4). Although suction curettage accounted for 85 percent of all reported abortions during the first 12 weeks of gestation, dilatation and evacuation was the major abortion method from 13 through 15 weeks of gestation, followed by intrauterine-instillation procedures after 15 weeks' gestation (Table 4).

TABLE 3 — Gestation, Type of Procedure, and Type of Facility for Abortion Procedures Percentage Distribution, Georgia, 1979 and 1980

	1979	*1980*
Weeks of Gestation		
≤8	45.7	48.9
9-10	29.3	30.4
11-12	13.6	13.3
13-15	3.1	2.3
16-20	4.7	2.8
≥21	3.5	1.5
Type of Procedure		
Curettage	98.0	96.7
Intrauterine Instillation	1.7	2.2
Hysterotomy/Hysterectomy/Other	0.3	0.2
Type of Facility		
Abortion Clinic	66.5	75.3
Hospital	21.2	17.8
Physician's Office	5.4	6.9
Other	4.7	0.0
Unknown	2.2	0.0

Note: Table excludes women for which these data were unknown (<1%).

Type of Facility

Most abortions were still being performed in freestanding clinics (Table 3). The percentage of abortions performed in clinics increased from 66.5 to 75.3 percent between 1979 and 1980.

The number of hospitals and abortion clinics in Georgia (98) remained essentially the same during 1980. However, one abortion clinic in central Georgia closed during mid-1980; this clinic reported performing 222 abortions in 1979.

Discussion

In 1980, the number of abortions reported to the Georgia DHR in 1980 declined. Two factors suggest this represents a true decline rather than a statistical artifact. First, both the DHR and the AGI reported a decline in the number of abortions performed,

Table 4 — Reported Legal Abortions by Type of Procedure and Estimated Weeks of Gestation, Percentage Distribution, Georgia, 1980

Type of Procedure	Weeks of Gestation ≤12 %	13-15 %	16-20 %	≥21 %	Unknown %	Total %
Suction Curettage	85.1	33.6	5.3	4.4	91.5	81.1
Sharp Curettage	12.7	1.4	0.8	0.2	4.2	11.5
Dilatation and Evacuation	1.8	60.5	35.6	0.6	2.4	4.1
Intrauterine Instillation	0.0	3.3	55.6	90.9	1.5	2.2
Hysterotomy/Hysterectomy/Other	0.2	0.4	0.8	1.3	0.3	0.2
Unknown	0.0	0.8	2.2	2.5	0.2	0.9
Total	100.0	100.0	100.0	100.0	100.0	100.0

although each institution used its own data-collection method. Each year AGI updates the abortion providers included in its survey, so it is unlikely that major providers are excluded from the survey. For 1979 and 1980, AGI obtained abortion estimates from 94 percent of its surveyed providers.[2]

Second, several states besides Georgia have reported a decrease in the number of abortions or a decline in the rate of increase in the number of abortions from 1979 to 1980.[2, 7] However, on the basis of 1 year of data we were unable to determine if the lower 1980 abortion rate is indicative of a downward trend in the number of abortions performed each year in Georgia.* In addition, we were unable to determine what effect, if any, the 1980 change in the reporting system had on underreporting of abortions.

In addition to examining the possibility of increased underreporting of abortions in 1980, we considered four other possible reasons for the decreased abortion rate: (1) an increase in the number of births to women aged 15-44; (2) changes in the number and policies of major abortion providers; (3) changes in public funding for abortions; and (4) an increase in the number of Georgia residents obtaining abortions in other states.

The decreased abortion rate was not due to an increased number of live births among women aged 15-44. We found slightly decreased or stable fertility rates for all age groups except women aged 30-34, for whom the rate increased slightly.

The lower abortion rate does not appear to be attributable to a declining number of abortion providers. Most abortion providers are still located in the Atlanta area, and the number of major providers and their policies in providing services has remained constant between 1979 and 1980.

On the basis of less than 1 year of data, it is not clear whether changes in public funding for abortions affected the number of abortions obtained. However, during 6 of the 7 months Medicaid funded abortions, the number of abortions reported decreased or remained the same compared with the number reported during the same month of the previous year. This suggests that the decline in the reported number of abortions was not due to funding changes.

Finally, the number of Georgia women obtaining abortions in other states does not appear to have affected the abortion rate. In 1979, a total of 1,834 Georgia residents obtained abortions in states other than Georgia, as compared with 1,864 in 1980.

It is not unusual for the DHR and the AGI to report different estimates of the number of abortions performed (Table 1). Since 1977, the number of abortions reported to the DHR has been at least 3 to 10 percent less than the number estimated by the AGI; in 1980 this difference increased to 12 percent. However, the fact that the AGI also reported fewer abortions in 1980 indicates a true decline in the number of abortions performed.

At least one study has suggested that increased underreporting of abortions is associated with increasing numbers of non-hospital providers of abortion services.[9] Therefore, the DHR has intensified efforts to inform abortion providers about the state's reporting and record-keeping regulations.

* Preliminary data indicate that during 1981 and 1982, a total of 28,832 and 29,804 induced abortions were performed, respectively, in Georgia compared with 33,288 in 1980.

Acknowledgments

We wish to thank the following individuals for their contributions to this paper: L. Morris, R. Rochat, and S. Davis.

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The Mythology of Low-Tar Cigarettes

With the percentage of Americans who smoke decreasing annually, the cigarette industry is continuing to advertise low-tar cigarettes as a way to keep Americans smoking a product which is supposedly safer than the high tar and nicotine brands. As an example, a record $150,000,000 has been spent in the campaign to advertise Barclay cigarettes, produced by Brown and Williamson Tobacco Company. Barclay has done surprisingly well in the marketplace, and one reason may be that its physiologic delivery of tar and nicotine may be higher than the advertised numbers.

The January, 1983, issue of *Consumer Reports* states that Barclay's new filter (which is also used in Kool Ultra and Kool Ultra 100's, also made by Brown and Williamson) contains four channels that lead air directly into the smoker's mouth where it is supposed to mix with smoke during inhalation, not mixing in the filter itself as with other cigarettes. In the Federal Trade Commission's smoking machine, the air coming through the channels mixing with smoke from the cigarette yields 1 mg of tar. The Federal Trade Commission has found, however, that the pressure of the smoker's lips is enough to partially or completely collapse these ventilation channels, thereby impeding the flow of external air. The real delivery of tar would appear to be three to seven times higher than that advertised by Brown and Williamson. Since tar content equals taste to smokers, this may explain why Barclay has been such a success — a "low-tar cigarette" that really isn't as low as its competition.

In another section of the same issue, *Consumer Reports* points out that Carlton cigarettes features an advertisement of only one style, the 85 mm box, which reports "ultra low" levels of tar and nicotine. Seven *other* package varieties, however, are the ones most generally available at retail outlets. These styles of Carlton all have a higher tar/nicotine content than the advertised style. If the cigarette industry is promoting ultra low-tar cigarettes, then making generally available only the other look-alike packages with higher amounts of tar and nicotine, the industry may be engaging in deceptive advertising tactics.

Another myth concerning low-tar cigarettes has to do with their alleged safety. In a recent report, the National Academy of Sciences[1] has shown that these new low-tar cigarettes are not really as safe as the tobacco companies would lead us to believe. Last year the Academy's review showed that smokers of low-tar, low-nicotine cigarettes tended to smoke more cigarettes, increased the depth of inhalation, frequency of puffing, in an apparent effort to offset the degree of reduction in nicotine from switching brands. This supposed safety in switching from a high-tar cigarette to one of the lower tar and nicotine variety is negated by the smoker's new habits. This report further reinforces the concept that nicotine is physically addicting, at least to some smokers.

Men who smoke cigarettes with lower levels of nicotine and carbon monoxide do not have a lower risk of myocardial infarction than men who smoke cigarettes with higher levels of these substances. The risk of heart attack increases with the number

of cigarettes smoked regardless of the amount of nicotine or carbon monoxide in the cigarette. A study of 502 men hospitalized with their first MI found almost three times the rate of MI among current smokers, regardless of the tar and nicotine content. Again, this negates the idea of a "safer cigarette" that the tobacco industry is trying to promote with its lower tar brands.[2]

The most recent nail in the "low-tar" coffin comes from *The New England Journal of Medicine,* pointing out that the actual nicotine content of low-tar cigarettes, when weighed, was *inversely* proportional to the advertised amount. This fact, coupled with the knowledge that smokers really do not enjoy vigor, enhanced sexuality, good looks or manliness/femininity from the use of the poisons is a further indication of the deceptive advertising used to lure the public into bad health practices.[3]

Data from Africa and Indonesia,[4] incidentally, indicate that cigarettes which are exported from the United States have a significantly higher tar content than cigarettes sold in this country under the same brand names.

Every physician in America should join with the American College of Chest Physicians, which recently launched a comprehensive smoking-cessation campaign at its 14th World Congress. The ACCP directed its members to actively educate and counsel their patients about the dangers of smoking and to work with other physicians and hospital administrators to adopt anti-smoking programs. This is the least we can do to fight America's number one health problem.

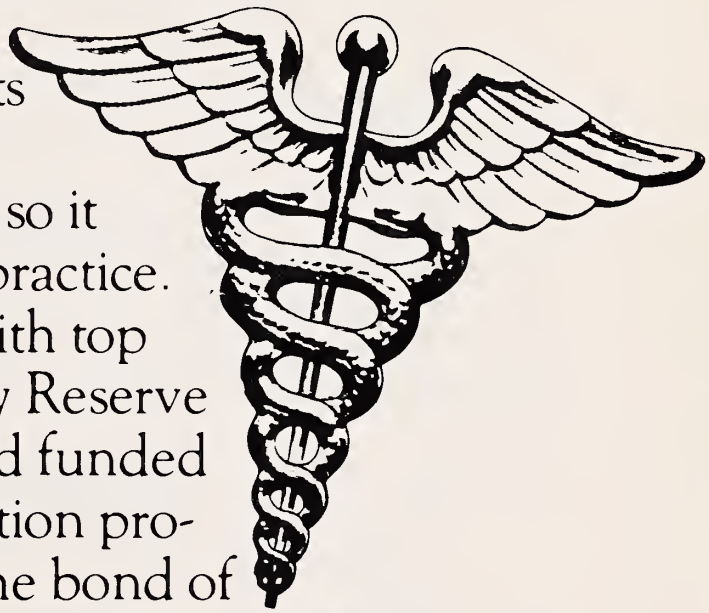
Thomas P. Houston, M.D.
National Coordinator of DOC
Associate Director, Family Practice Residency
Rome, Georgia

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Colorectal Health Check (CHECK)

JOHN PAGE WILSON, M.D., *Atlanta**

EARLY DETECTION PROGRAMS in colorectal cancer are not new to the American Cancer Society (ACS) or to Georgia physicians. They have always been a part of the cancer detection program of the American Cancer Society. For several years in Georgia, there has been a special effort directed towards this most common of all highly treatable cancers. Arch Avery has devoted much work in this effort to popularize the need for proctosigmoidoscopy and cancer detection in general.

Re-evaluation of current popular concepts and health practices as ascertained by a recent ACS commissioned study on "Cancer of the Colon and Rectum: The Public Perspective," as well as current diagnostic and treatment statistics and trends in management have demonstrated a clear need for a renewed emphasis on early detection of colorectal cancer.

CHECK emphasizes three diagnostic procedures: digital rectal examination, stool blood test, and proctosigmoidoscopy for asymptomatic patients.

At its annual meeting in November, 1983, the ACS launched a concentrated 3-year program known as Colorectal Health Check (CHECK) to improve results in the management of colorectal cancer. As in all of its early detection programs (such as that which was so successful with the Pap Smear for cervical cancer), the effort is directed toward public information, public education, and professional education.

In the area of public information, the goal of CHECK is to increase the public's awareness of colorectal cancer and to inform the public of early detection and preventive methods. The plan for public education is to increase the percentage of adults aged 50 and over reached annually with education programs on colorectal cancer.

The goal in professional education is to reach each family practitioner and other primary care physicians in Georgia with a continuing medical education program on the physician's role in the early detection of colorectal cancer.

Colorectal Health Check emphasizes three diagnostic procedures: 1) a digital rectal examination, 2) stool blood test, and 3) proctosigmoidoscopy for *asymptomatic* patients (the symptomatic patient demands definitive studies).

1. Digital rectal examination: Recommendation: This should be done annually on all patients over 40 years of age or high risk (significant family history for colorectal cancer, personal history of colon polyps or cancer, or chronic ulcerative

* Dr. Wilson practices general surgery and is a medical delegate of the American Cancer Society. Send reprint requests to him at 315 Boulevard, NE, Suite 555, Atlanta, GA 30312.

Prepared at the request of the Georgia Division, American Cancer Society. Others wishing to contribute papers to this page are invited to send them to Gray T. Fountain, M.D., 910 North Jefferson, Albany, GA 31708.

colitis). Data indicate that less than 50% of patients who have annual health exams have digital rectal exams as part of this process, and a much smaller percentage of the population at large have not had this simple elementary and fundamental health examination.

2. *Stool blood test: Recommendation:* This should be done annually on all patients over 50 years of age. Although this must be done with preparation and an understanding of exactly what its value and accuracy is, the test is still a very effective screening procedure done in conjunction with the total program advocated. In particular, properly done it has not resulted in an inordinate number of definitive tests resulting from false-positive blood stool. There also are data to indicate that the false-negative rate also is acceptable and quite low when done properly.

3. *Proctosigmoidoscopy: Recommendation:* This is recommended for patients over 50 years of age on an annual basis for 2 years and then, if negative, every 3 to 5 years. The implementation of routine sigmoidoscopy has been quite difficult over the past 2 to 3 decades of its advocacy because of the lack of acceptance on the part of both the patient and physician. Some of the objections can be overcome and a more effective examination be carried out with the 35 mm. flexible sigmoidoscope. In conjunction with the American Society of Gastrointestinal Endoscopy, the American Cancer Society is promoting physician education in the use of this instrument. The statistical change that has occurred in the location of colorectal cancers in the recent years has increased the need for this more effective examination as an alternative to the rigid endoscope. The latter, however, is obviously better than no examination at all.

It is clear that improvement can be made in early diagnosis and treatment of colorectal cancer, but this can only be done with a cooperative and knowledgeable public and profession. It is also clear that previous approaches must be altered to accommodate changing statistics in location, surgical proficiency, adjuvant radiation therapy, and a much more knowledgeable and acquiescent public.

It is hoped and anticipated that there will be an increasing public request for an appropriate diagnostic program in this area and it is expected that the request will be met appropriately and the program promulgated by the medical profession.

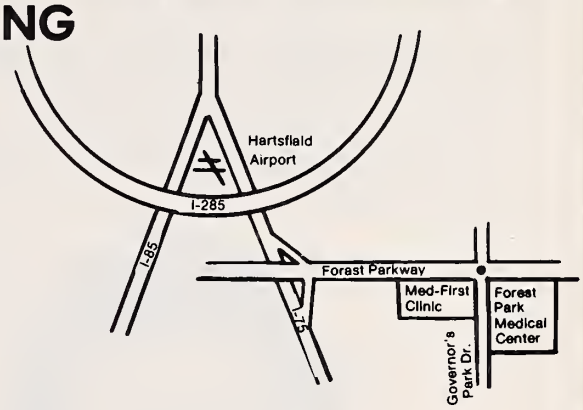
Program material, brochures, and information can be obtained from the local unit or the Georgia Division office of the American Cancer Society.

FOREST PARK MEDICAL & PROFESSIONAL CENTER



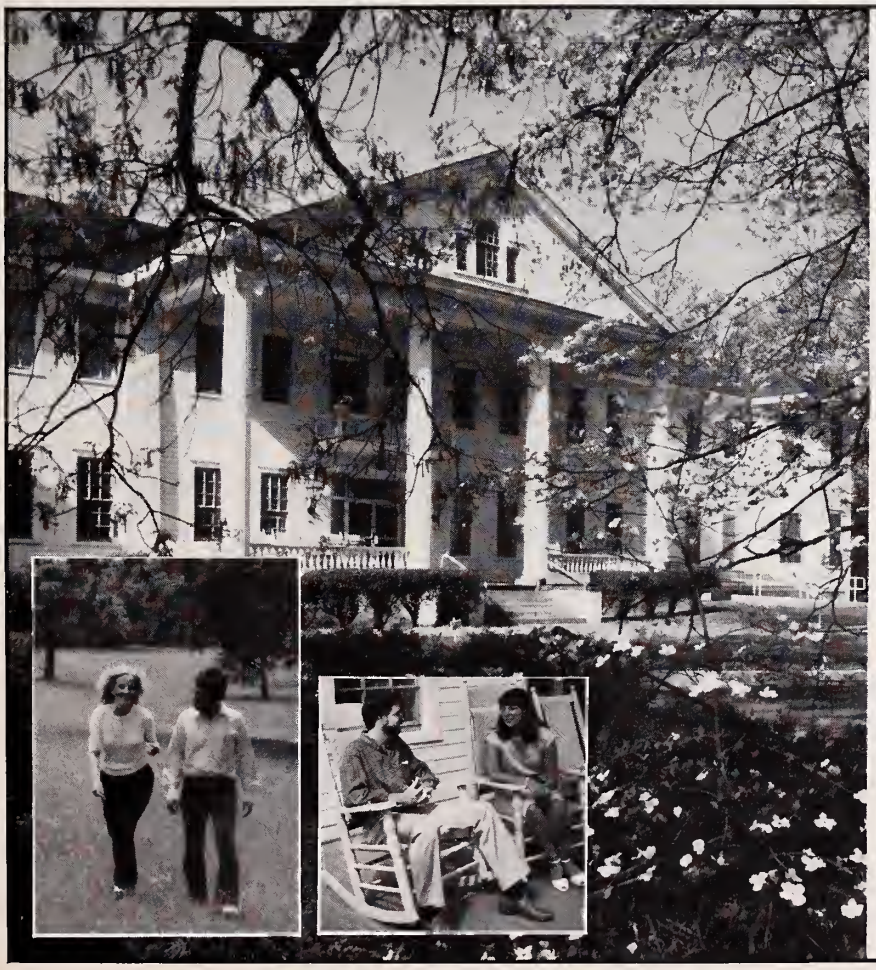
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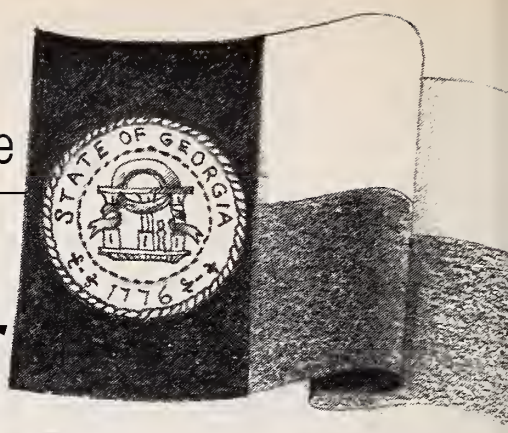
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Roche salutes the history of Georgia medicine

THE MODEST MAN OF MAJOR IMPORT



Dr. Crawford W. Long

One of the most important discoveries in medicine was the use of ether in surgical procedures, and its revelation was delayed because of the inordinate modesty of Dr. Crawford W. Long, its first successful user.

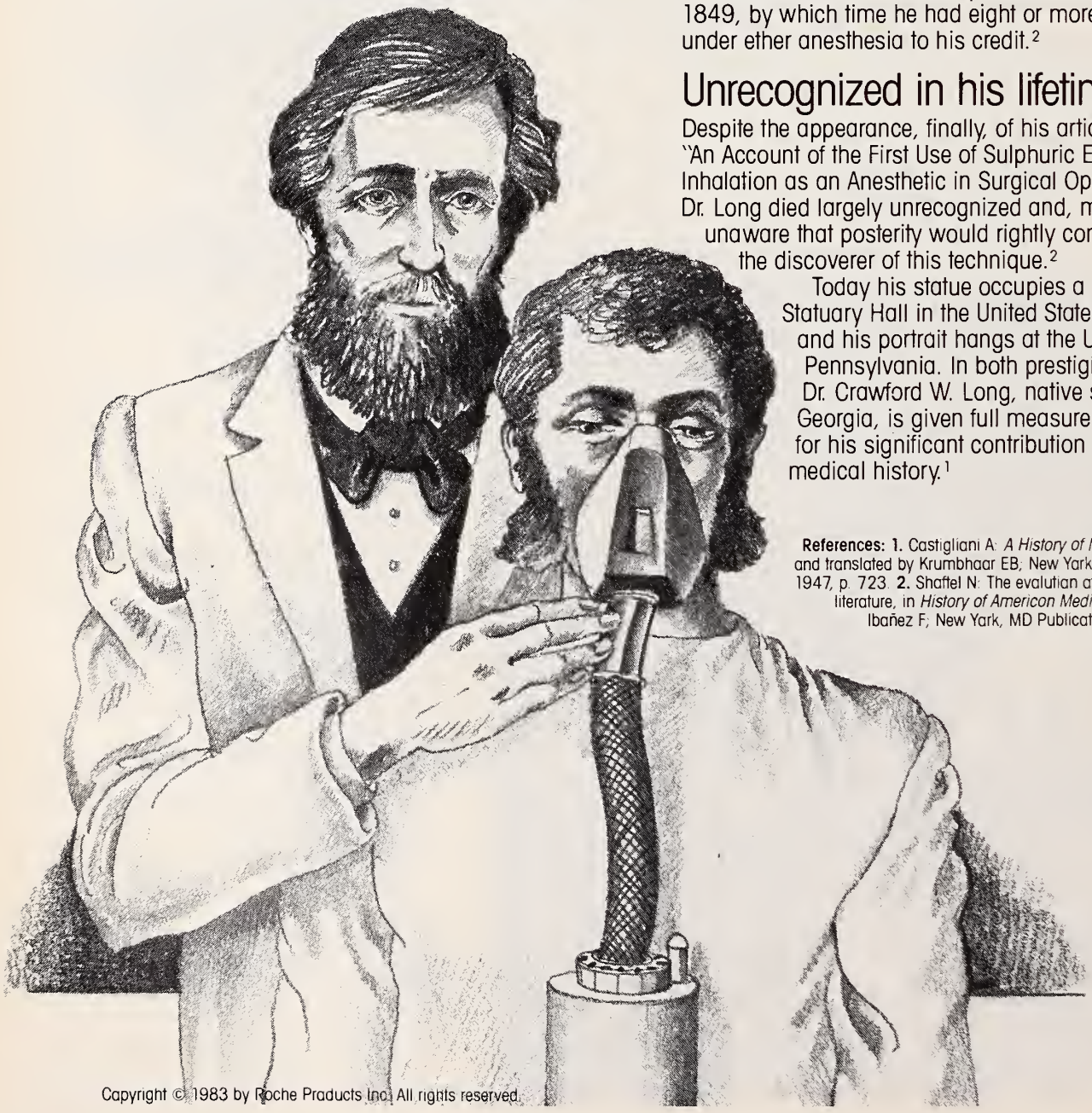
A simple country practitioner in Jefferson, Georgia, Dr. Long had little surgical experience when, on March 30, 1842, he experimented with the use of sulfuric ether as an anesthetic in the surgical removal of a small septic tumor from the neck of a patient. The patient, James Venable, reported feeling no pain during the incision and removal proceedings, and soon recovered.[1,2]

Pleased by the results of surgery under anesthesia, Dr. Long continued to use ether in surgery and obstetrics. Recognition for his accomplishment was limited, however, because he did not publish his discovery until 1849, by which time he had eight or more operations under ether anesthesia to his credit.[2]

Unrecognized in his lifetime

Despite the appearance, finally, of his article titled "An Account of the First Use of Sulphuric Ether by Inhalation as an Anesthetic in Surgical Operations," Dr. Long died largely unrecognized and, most assuredly, unaware that posterity would rightly consider him the discoverer of this technique.[2]

Today his statue occupies a place in Statuary Hall in the United States Capitol, and his portrait hangs at the University of Pennsylvania. In both prestigious locations, Dr. Crawford W. Long, native son of Georgia, is given full measure of respect for his significant contribution to medical history.[1]



References: 1. Castigliani A: *A History of Medicine*, edited and translated by Krumbhaar EB; New York, Alfred A. Knopf, 1947, p. 723. **2.** Shaftel N: The evalution of American medical literature, in *History of American Medicine*, edited by Marti-Ibañez F; New York, MD Publications, 1959, p. 107.

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ROCHE®

When the history reveals anxious depression...

For the estimated 70 percent of nonpsychotic depressed patients who are also anxious,[1] Limbitrol provides both amitriptyline, specific for symptoms of depression, and the effects of Librium® (chlordiazepoxide HCl), the tested and dependable anxiolytic. Limbitrol is, therefore, a better choice for these patients than dual agents that contain a phenothiazine, a class of antipsychotic drugs used infrequently in nonpsychotic patients.[1]

62% of Overall Improvement...Within the First Week

Limbitrol also has a rapid onset of action which may lead to greater patient compliance. In a multicenter study, patients taking Limbitrol experienced 62% of their overall improvement within the first week of therapy.[2]

In another multicenter study,[3] the following symptoms associated with anxious depression were significantly reduced during the first two weeks of therapy:

- ☐ Headache—79%
- ☐ Early insomnia—91%
  Middle insomnia—87%
  Late insomnia—89%
- ☐ Gastrointestinal upset—73%

In two multicenter studies, only 1.9% of Limbitrol patients experienced cardiovascular side effects.[3]

Patients should be cautioned about the combined effects with alcohol or other CNS depressants and about activities requiring complete mental alertness such as operating machinery or driving a car.

References: 1. Rickels K: Drug treatment of anxiety, in *Psychophormocology in the Proctice of Medicine,* edited by Jarvik ME; New York, Appleton-Century-Crofts, 1977, p. 316. **2.** Feighner JP *et al: Psychophormocology 61:*217-229, Mar 1979. **3.** Data on file, Hoffmann-La Roche Inc., Nutley, NJ.

In moderate depression and anxiety

Limbitrol® 5/12.5 10/25

Tablets 5-12.5 each containing 5 mg chlordiazepoxide and 12.5 mg amitriptyline (as the hydrochloride salt)
Tablets 10-25 each containing 10 mg chlordiazepoxide and 25 mg amitriptyline (as the hydrochloride salt)

Please see summary of product information on following page.

LIMBITROL TABLETS Ⓝ Tranquilizer—Antidepressant

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Relief of moderate to severe depression associated with moderate to severe anxiety.

Contraindications: Known hypersensitivity to benzodiazepines or tricyclic antidepressants. Do not use with monoamine oxidase (MAO) inhibitors or within 14 days following discontinuation of MAO inhibitors since hyperpyretic crises, severe convulsians and deaths have occurred with concomitant use; then initiate cautiously, gradually increasing dosage until optimal response is achieved. Contraindicated during acute recovery phase following myacardial infarction.

Warnings: Use with great care in patients with history of urinary retention ar angle-closure glaucoma. Severe constipation may occur in patients taking tricyclic antidepressants and anticholinergic-type drugs. Closely supervise cardiovascular patients. (Arrhythmios, sinus tachycardio and prolongation of conduction time reparted with use of tricyclic ontidepressonts, especially high doses. Myocardial inforction and stroke reported with use of this closs of drugs.) Caution patients about possible combined effects with alcohol and other CNS depressants and against hazardous occupations requiring complete mental alertness (e.g., operating machinery, driving).

***Usage in Pregnancy*: Use of minor tranquilizers during the first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.**

Since physical and psychological dependence to chlordiazepoxide have been reported rarely, use caution in administering Limbitrol to addiction-prone individuals or those who might increase dosage; withdrawal symptoms following discontinuation of either component alone have been reported (nausea, headache and malaise for amitriptyline; symptoms [including convulsions] similar to those of barbiturate withdrawal for chlordiazepoxide).

Precautions: Use with caution in patients with a history of seizures, in hyperthyroid patients or those on thyroid medication, and in patients with impaired renal or hepatic function. Because of the possibility of suicide in depressed patients, do not permit easy access to lorge quantities in these potients. Periodic liver function tests and blood counts are recommended during prolonged treatment. Amitriptyline component may block action of guanethidine or similar antihypertensives. Concomitant use with other psychotropic drugs has not been evoluated: sedative effects may be additive. Discontinue several days before surgery. Limit concomitant administrotion of ECT to essentiol treatment. See Warnings for precoutions about pregnancy. Limbitrol should not be taken during the nursing period. Not recommended in children under 12. In the elderly and debilitated, limit to smallest effective dosage to preclude ataxia, oversedation, confusion or anticholinergic effects.

Adverse Reactions: Most frequently reported are those ossociated with either cornponent alone: drowsiness, dry mouth, constipation, blurred vision, dizziness and bloating. Less frequently occurring reoctions include vivid dreams, impotence, tremor, confusion and nasal congestion. Mony depressive symptoms including anorexia, fotigue, weakness, restlessness and lethargy have been reported as side effects of both Limbitrol and amitriptyline. Gronulocytopenia, joundice and hepatic dysfunction hove been observed rarely.

The following list includes adverse reactions not reported with Limbitrol but requiring considerotion becouse they have been reported with one or both components or closely related drugs:

Cardiovascular: Hypotension, hypertension, tachycardia, palpitations myocardial infarction, orrhythmios, heort block, stroke.

Psychiatric: Euphoria, apprehension, poor concentration, delusions, hallucinations hypomania and increased or decreosed libido.

Neuralagic: Incoordination, ataxia, numbness, tingling ond poresthesias of the extremities, extrapyramidal symptoms, syncope, changes in EEG patterns.

Antichalinergic: Disturbance of accommodation, porolytic ileus, urinory retention, dilatation of urinary tract.

Allergic: Skin rash, urticaria, photosensitization, edema of foce and tongue, pruritus.

Hematalagic: Bone marrow depression including agranulocytosis, eosinophilia, purpura, thrombocytopenio.

Gastraintestinal: Nauseo, epigastric distress, vomiting, anorexia, stomatitis, peculiar taste, diarrhea, black tongue.

Endacrine: Testicular swelling and gynecomastia in the male, breast enlargement, galactorrheo and minor menstrual irregularities in the female and elevation and lowering of blood sugar levels.

Other: Headache, weight gain or loss, increased perspiration, urinary frequency, mydriasis, jaundice, alopecia, parotid swelling.

Overdosage: Immediately hospitalize patient suspected of having taken an overdose. Treatment is symptomatic and supportive. I.V. administration of 1 to 3 mg physostigmine salicylate has been reported to reverse the symptoms of amitriptyline poisoning. See complete product information for manifestation and treatment.

Dosage: Individualize according to symptom severity and patient response. Reduce to smallest effective dosage when satisfactory response is obtained. Larger portion of daily dose may be taken at bedtime. Single *h.s.* dose moy suffice for some patients. Lower dosages are recommended for the elderly.

Limbitrol 10-25, initial dosoge of three to four toblets daily in divided doses, increosed up to six tablets or decreased to two tablets doily as required. Limbitrol 5-12.5, initial dosage of three to four tablets daily in divided doses, for patients who do not tolerate higher doses.

How Supplied: White, film-coated tablets, each containing 10 mg chlordiazepoxide and 25 mg amitriptyline (os the hydrochloride salt) and blue, film-coated tablets, each containing 5 mg chlordiazepoxide and 12.5 mg omitriptyline (os the hydrochloride salt)—bottles of 100 and 500; Tel-E-Dose® packages of 100; Prescription Paks of 50

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Manati, Puerto Rico 00701

References:

1. Stone PH, Turi ZG, Muller JE: Efficacy of nifedipine therapy for refractory angina pectoris. *Am Heart J* 104:672-681, September 1982.
2. Antman E, Muller J, Goldberg S, et al: Nifedipine therapy for coronary-artery spasm: Experience in 127 patients. *N Engl J Med* 302:1269-1273, June 5, 1980.

BRIEF SUMMARY

PROCARDIA® (nifedipine) **CAPSULES** For Oral Use

INDICATIONS AND USAGE: I. Vasospastic Angina: PROCARDIA (nifedipine) is indicated for the management of vasospastic angina confirmed by any of the following criteria 1) classical pattern of angina at rest accompanied by ST segment elevation, 2) angina or coronary artery spasm provoked by ergonovine, or 3) angiographically demonstrated coronary artery spasm. In those patients who have had angiography, the presence of significant fixed obstructive disease is not incompatible with the diagnosis of vasospastic angina, provided that the above criteria are satisfied PROCARDIA may also be used where the clinical presentation suggests a possible vasospastic component but where vasospasm has not been confirmed, e.g . where pain has a variable threshold on exertion or in unstable angina where electrocardiographic findings are compatible with intermittent vasospasm, or when angina is refractory to nitrates and or adequate doses of beta blockers

II. Chronic Stable Angina (Classical Effort-Associated Angina): PROCARDIA is indicated for the management of chronic stable angina (effort-associated angina) without evidence of vasospasm in patients who remain symptomatic despite adequate doses of beta blockers and or organic nitrates or who cannot tolerate those agents.

In chronic stable angina (effort-associated angina) PROCARDIA has been effective in controlled trials of up to eight weeks duration in reducing angina frequency and increasing exercise tolerance, but confirmation of sustained effectiveness and evaluation of long-term safety in those patients are incomplete

Controlled studies in small numbers of patients suggest concomitant use of PROCARDIA and beta blocking agents may be beneficial in patients with chronic stable angina, but available information is not sufficient to predict with confidence the effects of concurrent treatment, especially in patients with compromised left ventricular function or cardiac conduction abnormalities When introducing such concomitant therapy, care must be taken to monitor blood pressure closely since severe hypotension can occur from the combined effects of the drugs (See Warnings.)

CONTRAINDICATIONS: Known hypersensitivity reaction to PROCARDIA

WARNINGS: Excessive Hypotension: Although in most patients, the hypotensive effect of PROCARDIA is modest and well tolerated, occasional patients have had excessive and poorly tolerated hypotension These responses have usually occurred during initial titration or at the time of subsequent upward dosage adjustment, and may be more likely in patients on concomitant beta blockers

Severe hypotension and or increased fluid volume requirements have been reported in patients receiving PROCARDIA together with a beta blocking agent who underwent coronary artery bypass surgery using high dose fentanyl anesthesia The interaction with high dose fentanyl appears to be due to the combination of PROCARDIA and a beta blocker, but the possibility that it may occur with PROCARDIA alone, with low doses of tentanyl, in other surgical procedures, or with other narcotic analgesics cannot be ruled out. In PROCARDIA treated patients where surgery using high dose fentanyl anesthesia is contemplated, the physician should be aware of these potential problems and, if the patient's condition permits, sufficient time (at least 36 hours) should be allowed for PROCARDIA to be washed out of the body prior to surgery.

Increased Angina: Occasional patients have developed well documented increased frequency, duration or severity of angina on starting PROCARDIA or at the time of dosage increases The mechanism of this response is not established but could result from decreased coronary perfusion associated with decreased diastolic pressure with increased heart rate, or from increased demand resulting from increased heart rate alone

Beta Blocker Withdrawal: Patients recently withdrawn from beta blockers may develop a withdrawal syndrome with increased angina, probably related to increased sensitivity to catecholamines Initiation of PROCARDIA treatment will not prevent this occurrence and might be expected to exacerbate it by provoking reflex catecholamine release. There have been occasional reports of increased angina in a setting of beta blocker withdrawal and PROCARDIA initiation It is important to taper beta blockers if possible, rather than stopping them abruptly before beginning PROCARDIA

Congestive Heart Failure: Rarely patients, usually receiving a beta blocker, have developed heart failure after beginning PROCARDIA Patients with tight aortic stenosis may be at greater risk for such an event

PRECAUTIONS: General: Hypotension: Because PROCARDIA decreases peripheral vascular resistance, careful monitoring of blood pressure during the initial administration and titration of PROCARDIA is suggested Close observation is especially recommended for patients already taking medications that are known to lower blood pressure. (See Warnings.)

Peripheral edema: Mild to moderate peripheral edema, typically associated with arterial vasodilation and not due to left ventricular dysfunction, occurs in about one in ten patients treated with PROCARDIA This edema occurs primarily in the lower extremities and usually responds to diuretic therapy With patients whose angina is complicated by congestive heart failure, care should be taken to differentiate this peripheral edema from the effects of increasing left ventricular dysfunction.

Drug interactions: Beta-adrenergic blocking agents: (See Indications and Warnings) Experience in over 1400 patients in a non-comparative clinical trial has shown that concomitant administration of PROCARDIA and beta-blocking agents is usually well tolerated, but there have been occasional literature reports suggesting that the combination may increase the likelihood of congestive heart failure, severe hypotension or exacerbation of angina

Long-acting nitrates: PROCARDIA may be safely co-administered with nitrates, but there have been no controlled studies to evaluate the antianginal effectiveness of this combination.

Digitalis: Administration of PROCARDIA with digoxin increased digoxin levels in nine of twelve normal volunteers The average increase was 45% Another investigator found no increase in digoxin levels in thirteen patients with coronary artery disease In an uncontrolled study of over two hundred patients with congestive heart failure during which digoxin blood levels were not measured, digitalis toxicity was not observed Since there have been isolated reports of patients with elevated digoxin levels, it is recommended that digoxin levels be monitored when initiating adjusting, and discontinuing PROCARDIA to avoid possible over- or under-digitalization

Carcinogenesis, mutagenesis, impairment of tertility When given to rats prior to mating, nitedipine caused reduced fertility at a dose approximately 30 times the maximum recommended human dose

Pregnancy Category C Please see full prescribing information with reference to teratogenicity in rats, embryotoxicity in rats, mice and rabbits, and abnormalities in monkeys

ADVERSE REACTIONS: The most common adverse events include dizziness or light-headedness, peripheral edema, nausea, weakness, headache and flushing each occurring in about 10% of patients, transient hypotension in about 5%, palpitation in about 2% and syncope in about 0 5% Syncopal episodes did not recur with reduction in the dose of PROCARDIA or concomitant antianginal medication Additionally, the following have been reported muscle cramps, nervousness, dyspnea, nasal and chest congestion, diarrhea, constipation, inflammation, joint stiffness, shakiness, sleep disturbances, blurred vision, difficulties in balance, dermatitis, pruntus, urticaria, fever, sweating, chills, and sexual difficulties Very rarely, introduction of PROCARDIA therapy was associated with an increase in anginal pain, possibly due to associated hypotension

In addition, more serious adverse events were observed, not readily distinguishable from the natural history of the disease in these patients It remains possible, however, that some or many of these events were drug related Myocardial infarction occurred in about 4% of patients and congestive heart failure or pulmonary edema in about 2%. Ventricular arrhythmias or conduction disturbances each occurred in fewer than 0 5% of patients

Laboratory Tests: Rare, mild to moderate, transient elevations of enzymes such as alkaline phosphatase, CPK, LDH, SGOT, and SGPT have been noted, and a single incident of significantly elevated transaminases and alkaline phosphatase was seen in a patient with a history of gall bladder disease after about eleven months of nifedipine therapy The relationship to PROCARDIA therapy is uncertain. These laboratory abnormalities have rarely been associated with clinical symptoms Cholestasis, possibly due to PROCARDIA therapy has been reported twice in the extensive world literature

HOW SUPPLIED: Each orange, soft gelatin PROCARDIA CAPSULE contains 10 mg of nifedipine PROCARDIA CAPSULES are supplied in bottles of 100 (NDC 0069-2600-66), 300 (NDC 0069-2600-72), and unit dose (10x10) (NDC 0069-2600-41) The capsules should be protected from light and moisture and stored at controlled room temperature 59° to 77°F (15° to 25°C) in the manufacturer's original container

More detailed professional information available on request

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"I can do things that I couldn't do for 3 yrs. including joining the human race again."



Quotes from an unsolicited letter received by Pfizer from an angina patient. While this patient's experience is representative of many unsolicited comments received, not all patients will respond to Procardia nor will they all respond to the same degree.

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"My daily routine consisted of sitting in my chair trying to stay alive."

"My doctor switched me to PROCARDIA[*] *as soon as it became available. The change in my condition is remarkable."*

"I shop, cook and can plant flowers again."

"I have been able to do volunteer work...and feel needed and useful once again."

PROCARDIA can mean the return to a more normal life for your patients—having fewer anginal attacks,[1] taking fewer nitroglycerin tablets,[2] doing more, and being more productive once again.

Side effects are usually mild (most frequently reported are dizziness or lightheadedness, peripheral edema, nausea, weakness, headache and flushing, each occurring in about 10% of patients, transient hypotension in about 5%, palpitation in about 2% and syncope in about 0.5%).



for the varied faces of angina

PROCARDIA®
(NIFEDIPINE) *Capsules 10 mg*

* Procardia is indicated for the management of:
1) Confirmed vasospastic angina.
2) Angina where the clinical presentation suggests a possible vasospastic component.
3) Chronic stable angina without evidence of vasospasm in patients who remain symptomatic despite adequate doses of beta blockers and/or nitrates or who cannot tolerate these agents. In chronic stable angina (effort-associated angina) PROCARDIA has been effective in controlled trials of up to eight weeks' duration in reducing angina frequency and increasing exercise tolerance, but confirmation of sustained effectiveness and evaluation of long-term safety in these patients are incomplete.

Please see PROCARDIA *brief summary on adjoining page.*

ZORprin® (ASPIRIN) ZERO ORDER RELEASE

Arthritis Therapy That Checks Out.

- Gastric distress is reduced. pH-dependent matrix virtually doesn't release in acidic stomach.
- ZORprin® (aspirin) is released in the alkaline environment of the small intestine.
- Zero-order release delivers drug at a constant rate, reducing serum peaks and valleys.



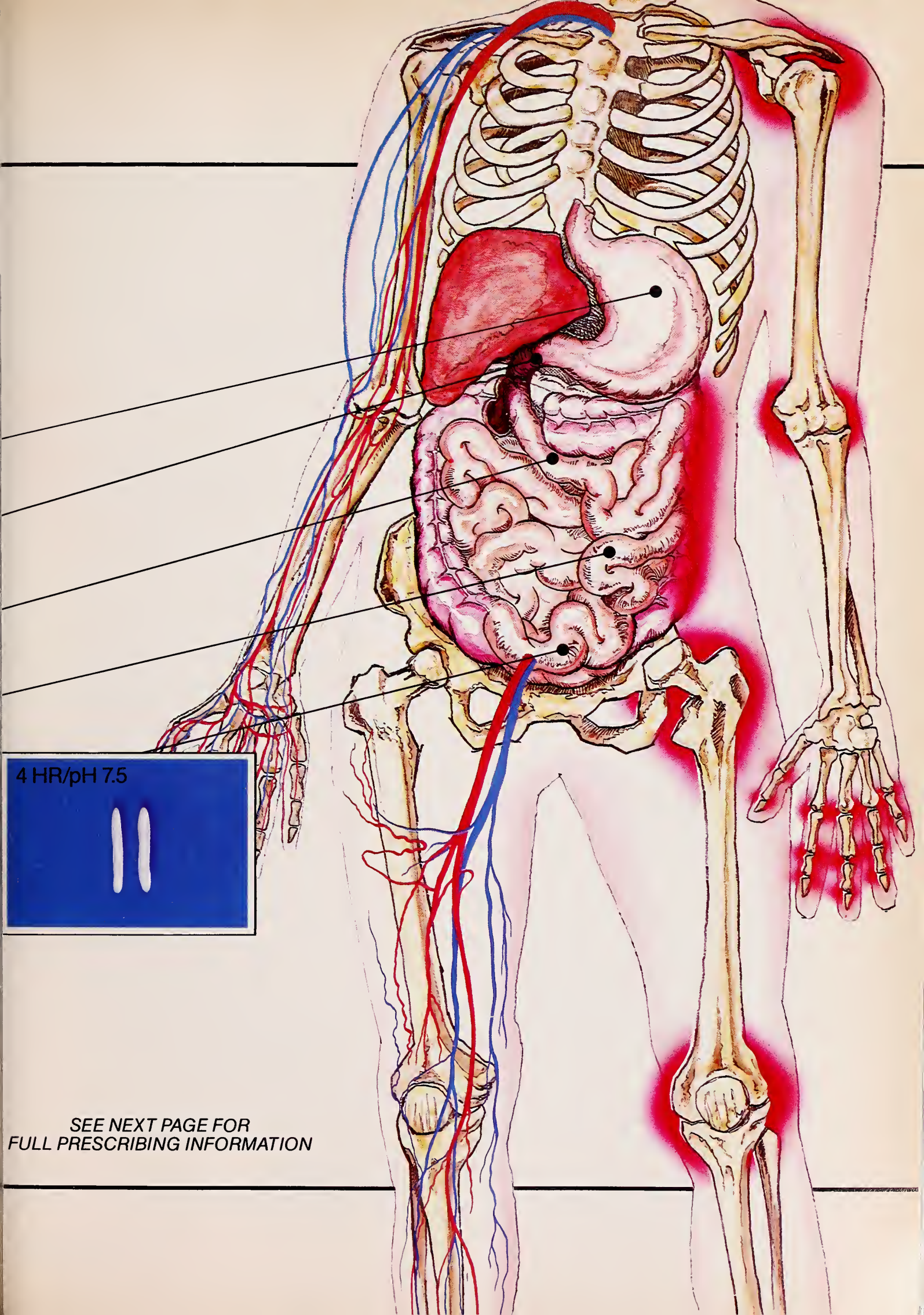


- Convenient b.i.d. dosage...enhances patient compliance.
- Economical...comparable efficacy and safety as other NSAIDs, yet costs approximately one-half as much.
- Your first step in arthritis therapy... ZORprin® (ASPIRIN) Zero-Order Release.

Pioneers in medicine for the family

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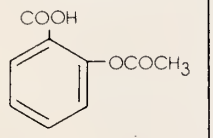


SEE NEXT PAGE FOR
FULL PRESCRIBING INFORMATION

ZORprin (ASPIRIN) Zero-Order Release

DESCRIPTION: Each capsule-shaped tablet of Zorprin contains 800 mg of aspirin, formulated in a special matrix to control the release of aspirin after ingestion. The controlled availability of aspirin provided by Zorprin approximates zero-order release; the *in vitro* release of aspirin from the tablet matrix is linear and independent of the concentration of the drug. □ **CLINICAL PHARMACOLOGY:** Aspirin, as contained in Zorprin, is a salicylate that has demonstrated anti-inflammatory and analgesic activity. Its mode of action as an anti-inflammatory and analgesic agent may be due to the inhibition of synthesis of prostaglandins, although its exact mode of action is not known. □ Zorprin dissolution is pH-dependent. *In vitro* studies have shown very little aspirin to be released in acidic solutions; whereas, Zorprin releases the majority of its aspirin (90%) in a zero-order mode at a neutral to alkaline pH. It is this pH dependence of Zorprin that reduces direct contact between aspirin and the gastric mucosa, resulting in a reduction of its gastrointestinal side-effect potential. □ Bioavailability data for Zorprin have confirmed that plasma levels of salicylic acid and acetylsalicylic acid can be measured 24 hours after a single oral dose. This substantiates a twice daily dose regimen. Multiple dose bioavailability studies showed similar steady-state salicylate levels for Zorprin as for conventional release aspirin using the same total daily dose. Long-term monitoring of salicylate levels showed no signs of accumulation once steady-state levels were reached (4-6 days). □ Studies of *in vivo* prostaglandin levels (PGE2) have shown Zorprin plasma levels of salicylic acid and acetylsalicylic acid to reduce PGE2 levels 14 hours after a single oral 800 mg dose while an equivalent dose of aspirin produced a reduction of PGE2 levels only through six hours. Zorprin's effect on prostaglandins other than PGE2 has not been determined. □ Salicylates are excreted mainly by the kidney, and from studies in humans it appears that salicylate is excreted in the urine as free salicylic acid (10%); salicyluric acid (75%) salicylic phenolic (10%); acyl glucuronides (5%) and gentisic acid (<1%). □ **INDICATIONS & USAGE:** Zorprin is indicated for the treatment of rheumatoid arthritis and osteoarthritis. The safety and efficacy of Zorprin have not been established in those rheumatoid arthritic patients who are designated by the American Rheumatism Association as Functional Class IV (incapacitated, largely or wholly bedridden, or confined to wheelchair, little or no self-care). □ In patients treated with Zorprin for rheumatoid arthritis and osteoarthritis, the anti-inflammatory action of Zorprin has been shown by reduction in pain, morning stiffness and disease activity as assessed by both the investigators and patients. □ In clinical studies in patients with rheumatoid arthritis and osteoarthritis, Zorprin has been shown to be comparable to conventional release aspirin in controlling the aforementioned signs and symptoms of disease activity and to be associated with a statistically significant reduction in the milder gastrointestinal side effects (see ADVERSE REACTIONS). Zorprin may be well tolerated in some patients who have had gastrointestinal side effects with conventional release aspirin, but these patients when treated with Zorprin should be carefully followed for signs and symptoms of gastrointestinal bleeding and ulceration. □ Since there have been no controlled trials to demonstrate whether or not there is any beneficial effect or harmful interaction with the use of Zorprin in conjunction with other nonsteroidal anti-inflammatory agents (NSAI), the combination cannot be recommended (see **Drug Interactions**). □ **Because of its relatively long onset of action, Zorprin is not recommended for antipyresis or for short-term analgesia.** □ **CONTRAINDICATIONS:** Zorprin should not be used in patients known to be hypersensitive to salicylates or in individuals with the syndrome of nasal polyps, angioedema, bronchospastic reactivity to aspirin, renal or hepatic insufficiency, hypoprothrombinemia or other bleeding disorders. Zorprin is not recommended for children under 12 years of age; it is contraindicated in all children with fever accompanied by dehydration. □ **WARNINGS:** Zorprin should be used with caution when anticoagulants are prescribed concurrently, since aspirin may depress platelet aggregation and increase bleeding time. Large doses of salicylates may have hypoglycemic action and enhance the effect of the oral hypoglycemics, concomitant use therefore is not recommended. However, if such use is necessary, dosage of the hypoglycemic agent must be reduced. The hypoglycemic action of the salicylates may also necessitate adjustment of the insulin requirements of diabetics. □ While salicylates in large doses have a uricosuric effect, smaller amounts may reduce water excretion and increase serum uric acid. □ USE IN PREGNANCY: Aspirin can harm the fetus when administered to pregnant women. Aspirin interferes with maternal and infant hemostasis and may lengthen the duration of pregnancy and parturition. Aspirin nas produced teratogenic effects and increases the incidence of stillbirths and neonatal deaths in animals. □ If this drug is used during pregnancy, or if the patient becomes pregnant while taking this drug, the patient should be apprised of the potential hazard to the fetus. □ Aspirin should not be taken during the last 3 months of pregnancy. □ **PRECAUTIONS:** Appropriate precautions should be taken in prescribing Zorprin for patients who are known to be sensitive to aspirin or salicylates. Particular care should be used when prescribing this medication for patients with erosive gastritis, peptic ulcer, mild diabetes or gout. As with all salicylate drugs, caution should be exercised in prescribing Zorprin for those patients with bleeding tendencies or those on anticoagulants. □ In order to avoid exacerbation of disease or adrenal insufficiency, patients who have been on prolonged corticosteroid therapy should have their therapy tapered slowly rather than discontinued abruptly when Zorprin is made a part of the treatment program. □ Patients receiving large doses of aspirin and/or prolonged therapy may develop mild salicylate intoxication (salicylism) that may be reversed by dosage reduction. □ Salicylates can produce changes in thyroid function tests. □ Salicylates should be used with caution in patients with severe hepatic damage, preexisting hypoprothrombinemia, Vitamin K deficiency and in those undergoing surgery. □ Since aspirin release from Zorprin is pH dependent, it may change in those conditions where the gastric pH has been increased as a result of antacids, gastric secretion inhibitors or surgical procedures. □ **Drug Interactions:** (See **WARNINGS**) Aspirin may interfere with some anticoagulant and antidiabetic drugs. Drugs which lower serum uric acid by increasing uric acid excretion (uricosurics) may be antagonized by the concomitant use of aspirin, particularly in doses less than 2.0 grams/day. Nonsteroidal anti-inflammatory drugs may be competitively displaced from their albumin binding sites by aspirin. This effect may negate the clinical efficacy of both drugs. Also, the gastrointestinal inflammatory potential of nonsteroidal anti-inflammatory drugs may be potentiated by aspirin. The combination of alcohol and aspirin may increase the risk of gastrointestinal bleeding. □ Aspirin may enhance the activity of methotrexate and increase its toxicity. □ Sodium excretion produced by spironolactone may be decreased in the presence of salicylates. Concomitant administration of other anti-inflammatory drugs may increase the risk of gastrointestinal ulceration. Urinary alkalinizers decrease aspirin's effectiveness by increasing the rate of salicylate renal excretion. Phenobarbital decreases aspirin's effectiveness by enzyme induction. □ **Pregnancy Category D.** See **WARNINGS** Section. □ **Nursing Mothers:** Salicylates have been detected in the breast milk of nursing mothers. Because of the potential for serious adverse reactions from aspirin in nursing infants, a decision should be made whether to discontinue nursing or discontinue the drug, taking into account the benefit of the drug to the mother. □ **ADVERSE REACTIONS: Hematologic:** Aspirin interferes with hemostasis. Patients with a history of blood coagulation defects or receiving anti-coagulant drugs or with severe anemia should avoid Zorprin. Aspirin used chronically may cause a persistent iron deficiency anemia. □ **Gastrointestial:** Aspirin may potentiate peptic ulcer, and cause stomach distress or heartburn. Aspirin can cause an increase in occult bleeding and in some patients massive gastrointestinal bleeding. However, the greatest release of active drug from Zorprin is designed to occur in the small intestine over a period of time. This has resulted in fewer symptomatic gastrointestinal side effects. □ **Allergic:** Allergic and anaphylactic reactions have been noted when hypersensitive individuals have taken aspirin. Fatal anaphylactic shock, while not common, has been reported. □ **Respiratory:** Aspirin intolerance, manifested by exacerbations of bronchospasm and rhinitis, may occur in patients with a history of nasal polyps, asthma, or rhinitis. The mechanism of this intolerance is unknown but may be the result of aspirin-induced shunting of prostaglandin synthesis to the lipoxygenase pathway and the liberation of leukotrienes, e.g: slow-reacting substance of anaphylaxis. □ **Dermatologic:** Hives, rashes, and angioedema may occur, especially in patients suffering from chronic urticaria. □ **Central Nervous System:** Taken in overdoses, aspirin provides stimulation which may be manifested by tinnitus. Following initial stimulation, depression of the central nervous system may be noted. □ **Renal:** Aspirin rarely may aggravate chronic kidney disease. □ **Hepatic:** High doses of aspirin have been reported to produce reversible hepatic dysfunction. □ **OVERDOSAGE:** Overdosage, if it occurs, would produce the usual symptoms of salicylism: tinnitus, vertigo, headache, confusion, drowsines, sweating, hyperventilation, vomiting or diarrhea. Plasma salicylate levels in adults may range from 50 to 80 mg/dl in the mildly intoxicated patient to 110 to 160* mg/dl in the severely intoxicated patient. An arterial blood pH of 7.1 may indicate serious poisoning. The clearance of salicylates in children is much slower than adults and should receive due consideration when aspirin overdosages occur in infants; salicylate half-lives of 30 hours have been reported in infants 4-8 months old. Treatment for mild intoxication should include emptying the stomach with an emitic, or gastric lavage with 5% sodium bicarbonate. Individuals suffering from severe intoxication should, in addition, have forced diuresis by intravenous infusions of sodium bicarbonate and dextrose or sodium lactate. In extreme cases, hemodialysis or peritoneal dialysis may be required. □ (*A plasma salicylate level of 160 mg/dl in an adult is usually considered lethal.) □ **DOSAGE & ADMINISTRATION:** *In order to achieve a zero-order release, the tablets of Zorprin should be swallowed intact.* □ *Breaking the tablets or disrupting the structure will alter the release profile of the drug.* □ *It is recommended that Zorprin be taken with sufficient quantities of fluids (8 oz. or more).* □ **Adult Dosage:** For mild to moderate pain associated with rheumatoid arthritis and osteoarthritis, the recommended initial dose of Zorprin is 1600 mg (2-800 mg tablets) twice a day. Because of Zorprin's prolonged release of aspirin into the bloodstream, Zorprin tablets may be taken as a b.i.d. dose. Further adjustment of the dosage should be determined by the physician, based upon the patient's response and needs. Since it will take 4-6 days to reach steady-state levels of salicylic acid with Zorprin, it is recommended dosages be given for at least one week before further adjustment. In general, patients with rheumatoid arthritis seem to require higher doses of Zorprin than do patients with osteoarthritis. □ **Zorprin is not recommended for children below the age of 12.** □ **HOW SUPPLIED: Zorprin Tablets 800 mg;** plain, white capsule-shaped tablets. □ Bottles of 100 Tablets — NDC 0524-0057-01. □ **Caution:** Federal law prohibits dispensing without prescription. □ U.S. Patent No. 4,308,251. □ **Manufactured and Distributed by: BOOTS PHARMACEUTICALS, INC., Shreveport, Louisiana 71106 U.S.A.**

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Step-Care Approach to Hyperlipidemia: Guidelines for Clinicians

JOHN D. CANTWELL, M.D., *Atlanta**

Introduction

HYPERLIPIDEMIA is an important risk factor for atherosclerosis. Recent studies of both the pathogenesis of coronary atherosclerosis and lipid metabolism have enhanced our understanding of the role lipoproteins play in this disease.[1] Most physicians would agree that control of hyperlipidemia should be part of primary and secondary coronary disease prevention.

The relationship between serum cholesterol level and coronary disease incidence is linear. In other words, the higher the level, the higher the risk of disease. The ideal serum cholesterol level is probably below 180 mg/dl. Concern about an increased cancer risk associated with low cholesterol levels has not been substantiated.[2] High density lipoprotein (HDL) has a protective effect against coronary disease, possibly due to its role in reducing low density lipoprotein (LDL) uptake by the cell or in transporting cholesterol away from the cell. The ratio of HDL to total cholesterol is important in assessing coronary risk. A ratio of 1:3 would seem ideal. The ratio seems less important in certain populations (like the Tarahumara Indians[3]) who have very low total cholesterol and LDL cholesterol levels. An elevated serum triglyceride level has been de-emphasized as an independent coronary risk factor;[4] however, there may be subgroups of individuals with type IV hyperlipoproteinemia (such as those with elevated apoprotein B levels[5]) who are prone to coronary atherosclerosis. Future emphasis will undoubtedly be placed on the role of apoproteins (''A'' through ''H'').[6] Preliminary studies suggest that low levels of apoprotein A-1 may predict the presence of coronary lesions in patients undergoing angiography better than HDL levels.[7]

A clinician must make therapeutic decisions based on information available at the moment. Ideal studies demonstrating the efficacy of control of hyperlipidemia are not available at present but may be forthcoming. For example, in the Lipid Research Clinics Study,[8] 3,810 men with heterozygous familial hypercholesterolemia, age 35-59, free of coronary symptoms have been placed on diets and randomized to either cholestyramine (24 gm/day) or placebo. Recently published results suggest that drug therapy is beneficial.[9] With this in mind, I advocate the following step-care approach to hyperlipidemia.

Step-Care Approach

Step 1 — Repeat testing of blood lipid levels when initial values are elevated. A single determination of blood lipid levels can be likened to a single reading of

* Dr. Cantwell is Director of Internal Medicine and the Preventive Medicine Institute, Georgia Baptist Medical Center, Atlanta. Send reprint requests to him at 300 Boulevard NE, Atlanta, GA 30312.

Articles for this page are sponsored and approved by the American Heart Association, Georgia Affiliate. Those wishing to contribute papers to this page are invited to send them to Dr. Laurence O. Watkins, ''Heart Page'' Editor, Section of Cardiology, Dept. of Medicine, MCG, Augusta, GA 30909.

blood pressure. In both instances, it is best to obtain an average of several readings before initiating therapy.

Step 2 — Use life-style modification to treat all aberrant lipid levels.

Cardiovascular disease presents enormous medical problems in the United States. Despite its downward trend in incidence, it still accounts for 51 percent of all deaths. Although recent developments in the diagnosis and therapy of this disease have been impressive, prevention would seem the most logical approach, as has been the case with infectious diseases.

Recent data from the Lipid Research Clinics[8] provide percentiles for lipid levels in American men and women. For example, a serum cholesterol level of 230 mg/dl in a 43-year-old white man places him in the 75th percentile for his age group and a reading of 250 mg/dl in the 90th percentile. In the Pooling Project, men above the 80th percentile in serum cholesterol accounted for over half the excess coronary events attributable to hypercholesterolemia.

I like to have patients work toward reducing their serum cholesterol level to less than the 50th percentile for their sex and age. In a practical sense, this usually implies aiming for a cholesterol level of < 180 mg/dl and a serum LDL level of < 100 mg/dl. I also encourage them to strive toward a serum HDL level of up toward 60 mg/dl, or about one-third of the total cholesterol level. To achieve these ends, the following recommendations are given:

a) Reduce caloric intake to a level necessary to achieve the desirable level of body fat (< 14 percent for men, < 17 percent for women, based on skinfold caliper measurements).

b) Reduce saturated fat intake to about 10% of total calories, and total fat intake to less than 35% of total caloric intake.

c) Follow the American Medical Association's phase 1, 2, or 3 dietary cholesterol reduction plan[4] (≤ 300 mg, ≤ 250 mg, or ≤ 100 mg/day, respectively) to achieve the desired goal.

d) Achieve at least 40 Cooper aerobic points of endurance exercise per week.[10]

e) Avoid habits and use of drugs or other substances known to affect serum lipids adversely. For example, cigarette smoking and use of dietary supplements of zinc are both associated with reduced serum HDL levels. Diuretics may also affect lipid levels in a negative way.

The following case illustrates the response that can be achieved with such an approach:

Case #1

A 52-year-old airline pilot was seen for a routine evaluation on October 8, 1973. He had poor dieting habits, did not exercise, and consumed alcohol in excess. He began a low-level exercise program and had not made any dieting modifications when evaluated 4 months later. Four and one-half years later, when his weight reached 235 lbs (Table 1), he agreed to enter our medically-supervised rehabilitation program, which combined vigorous exercise and a low-fat diet. Within 3 months, he achieved appreciable reductions of serum cholesterol and triglyceride levels and body weight, as well as an improved level of cardiorespiratory fitness.

Table 1 — Studies on Case # 1

Date	*Weight (lbs)*	*%Body Fat*	*Chol (mg/dl)*	*HDL (mg/dl)*	*Trigl (mg/dl)*	*TTT (min)**	*VO_2†*
10/8/73	208.5	18.2	—	—	249	4.8	21.7
2/1/74	210	21.6	276	—	312	6.3	29.5
3/9/78	235	24.2	254	42	720	9.1	30.8
6/15/78**	198	17.4	149	44	50	11.5	35.2

* TTT = treadmill test time, Bruce protocol.
† VO_2 = peak oxygen consumption during exercise, expressed in ml/kg/min.
** Entered medically supervised rehabilitation program.

Step 3 — Use drug therapy when the serum cholesterol level exceeds the 90th percentile despite efforts in Step 2.

Elevated cholesterol levels are treated with either colestipol or cholestyramine. Patients are started on a low dose (4-5 gm once daily, mixed with fluid of choice and taken just before meals) to familiarize them with the medication and to minimize side effects (mainly distaste and constipation) which may cause them to reject further therapy. The dose is gradually increased to 10 gm three times daily (for colestipol) or 8 gms three times daily (for cholestyramine) if necessary. The dose can also be given on a twice daily schedule. I avoid the use of probucol alone because it lowers the HDL level, though it may be employed as a component of combined drug therapy.

Step 4 — Combined drug therapy for persistent hypercholesterolemia.

When serum cholesterol levels remain > 250 mg/dl despite use of bile acid sequestering agents (or if only suboptimal doses of the latter are tolerated), nicotinic acid is added. The starting dose is 100 mg three times daily with meals and is gradually increased to 6-8 grams per day, with monitoring of biochemical parameters at 2-3 month intervals. Initial side effects, flushing and pruritus, tend to diminish with time. The use of aspirin 30 minutes before the dose may minimize these reactions, probably by reducing prostaglandin synthesis. Abnormalities in liver function tests can be minimized by keeping the dose increase of nicotinic acid below 2.5 gm/day/month (Table 2). Gastric irritation with nicotinic acid may be alleviated by taking the drug with antacids or after meals.

Table 2 — Therapeutic Guidelines for Nicotinic Acid

1. **Take with meals.**
2. **If stomach upset occurs, take after meals and with antacids.**
3. **If flushing does not improve with time, take aspirin 30 minutes before niacin.**
4. **DOSE SCHEDULE (Increasing to tolerance or until desired lipid level achieved):**

Week	Dose
1	100 mg 3 ×/d
2-3	200 mg 3 ×/d
*4-5	300 mg 3 ×/d
6-7	500 mg 3 ×/d
*8-11	1.0 gm 3 ×/d
*12-15	1.5 gm 3 ×/d
16-19	2.0 gm 3 ×/d
*20-on	2.5 gm 3×/d

* = CBC, SMA-12.

Probucol can also be added to colestipol or cholestyramine, since the latter drugs will counter the fall in HDL. The dose of probucol is 500 mg twice daily.

The following cases illustrate the effects of dual drug therapy:

Case #2

A 45-year-old man has been followed with familial hypercholesterolemia and symptomatic coronary disease since 1976. His father died of a myocardial infarction at age 44, as did both paternal uncles (ages 55 and 57). All had tendinous xanthomas of the hands and feet. Diet and exercise therapy were unsuccessful in controlling his cholesterol level, although it did reduce the serum triglyceride level from 224 mg/dl to 100 mg/dl. Colestipol alone was likewise unsatisfactory, and the patient did not comply with a dose above 15 gm/day. Nicotinic acid (up to 500 mg three times daily) was added, and the serum cholesterol level was reduced from 366 mg/dl to 275 mg/dl (Table 3).

Case #3

A 48-year-old man, also with symptomatic coronary disease and familial hypercholesterolemia, had the following blood lipid levels on December 18, 1980: serum cholesterol, 965 mg/dl; LDL cholesterol, 862 mg/dl; HDL cholesterol, 46 mg/dl; triglyceride, 286 mg/dl. On combined therapy with colestipol (15 gm/day) and nicotinic acid (4.0 gm/d), his lipid levels over the

Table 3 — Studies on Case # 2

Date	*Weight (lbs)*	*Body Fat (%)*	*Chol (mg/dl)*	*Trigl (mg/dl)*	*HDL (mg/dl)*
7/2/76	—	—	355	224	—
10/6/76	173	18.4	341	100	—
9/2/77*	174	20.3	366	130	57
5/24/78**	169.5	17.6	275	57	52

* After colestipol added.
** On therapy with colestipol and niacin.

ensuing 7 months were altered as follows: serum cholesterol, 340 mg/dl; LDL cholesterol, 282 mg/dl; HDL cholesterol, 34 mg/dl; triglyceride, 121 mg/dl.

As in the treatment of hypertension, step-down therapy can be used when satisfactory results are achieved to keep drug use at the lowest necessary dose. This situation might arise in a patient, previously non-compliant with dietary measures, who may suddenly decide to adhere to a low-caloric, low-fat regimen.

Step 5 — Combined drug therapy for hypercholesterolemia plus hypertriglyceridemia.

When marked hypertriglyceridemia persists despite Step 4, triple drug therapy (adding gemfibrozil) is recommended. The following case is one example:

Case #4

A 53-year-old man with prior myocardial infarction and coronary bypass surgery had persistent hypertriglyceridemia despite double drug therapy (colestipol, 30 gm/day; nicotinic acid, 6 gm/day). Gemfibrozil was added in July, 1982, with the following results:

	6/3/82	*11/11/82*	*1/12/83*
Cholesterol	492	347	252
LDL (mg/dl)	182	228	127
HDL (mg/dl)	15	22	50
Triglyceride (mg/dl)	1,475	484	375

Step 6 — Consider referral to a University Center for a trial of experimental agents when all else fails.

Two recently developed drugs, compactin and mevinolin, are competitive inhibitors of the enzyme, 3-hydroxy-3 methylglutaryl coenzyme A (HMG-CoA) reductase, which controls the rate-limiting step in cholesterol synthesis. Currently being studied in Japan, they can be used alone or combined with bile-acid sequestrants. A recent report of such combined therapy in 10 heterozygous patients with familial hypercholesterolemia revealed the following results:[11]

	Diet Alone	*Diet Plus Cholestyramine*	*Diet Plus Cholestyramine Plus Compactin*
Cholesterol (mean; mg/dl)	356	285	217
VLDL (mean; mg/dl)	23	17	15
LDL (mean; mg/dl)	263	190	125
HDL (mean; mg/dl)	36	50	52

Step 7 — Screen relatives of subjects with hyperlipidemia.

A recent study[12] assessed lipid levels of 833 offspring and 1,194 siblings of people found to be in the 90th percentile for serum cholesterol. About 23 percent of both the offspring and the siblings were in the same elevated cholesterol percentile, which emphasizes the importance of family screening for new case detection in hyperlipidemia.

Summary

Hyperlipoproteinemia is a major coronary risk factor and a common clinical

problem. A practical step-care approach is outlined, based on the current state of the art. The latter should be enhanced when results of ongoing investigations such as the Lipid Research Clinic Study are completed.

Promising new drugs, used alone or in combination with ones already available, offer hope to patients with hyperlipidemia. Family screening deserves more emphasis.

A better understanding of apoproteins (both qualitative and quantitative) should shed new light on this complex topic.

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Legislation With Dignity: Will This Be The Year Georgia Enacts A "Living Will" Statute?

GEORGE M. MAXWELL, JR., *Atlanta**

As this article goes to press, it appears that the 1984 Georgia General Assembly will once again consider according Georgians the "right to die with dignity." The "Living Will Bill" (Senate Bill No. 186) was introduced in the Senate during the 1983 legislative session and assigned to the Senate Committee on Judiciary and Constitutional Law. If enacted, the Bill may serve to insert "some degree of certainty and predictability in an area where uncertainty and unpredictability have been rampant."[1]

Although conceptually similar to Living Will legislation previously considered by the Georgia legislature,[2] the present Bill appears to enjoy renewed public support, both in Georgia and elsewhere, for an individual's "right to die with dignity." Public interest in the inevitable conflict between the ability of medical science to prolong human life (in spite of debilitating illness or injury) and the desire of individuals for autonomy in subjecting themselves to extraordinary medical treatment appears to have been rekindled by the publicity surrounding the case of *Young v. Emory University Hospital*[3] and the enactment of Living Will legislation in other states.[4] This article will preview the important issues that the Legislature is likely to address in its consideration of the Bill by first setting forth the general purpose of the Bill and then discussing the specific problems with which the Bill must deal.

General Purpose of the Living Will Bill

In general, the Bill would grant an individual the right to decide in advance, in very limited circumstances, whether to employ certain medical or surgical treatment to prolong his or her existence. Under the current state of the law, the uncertainty and unpredictability surrounding the physician's and hospital's liability undermine the right of an individual to determine the extent of the medical treatment that he or she may be given if unable to object to the treatment at the time it is administered (as amply evidenced by the cumbersome process involved in the *Young* case).[5] For example, if a physician administers treatment to an unconscious or mentally incompetent patient who has refused consent to such treatment through a prior act, the physician may incur civil and criminal liability for assault and battery — for treating the patient without receiving the requisite actual or implied consent. If, however, the physician withholds or withdraws treatment in accordance with the patient's expressed wish, and the patient dies as a result, the physician

* Prepared at the request of the Medical Association of Georgia. Mr. Maxwell is an associate in the firm of Powell, Goldstein, Frazer & Murphy, General Counsel to the Association, 1100 C & S National Bank Building, Atlanta, GA 30335.

may incur civil and criminal liability for the patient's death should the patient be ruled to have been incompetent to withhold consent.

Under the Bill, a competent adult may execute a directive, termed a "living will," that will preclude or terminate certain life-sustaining procedures should he or she lapse into a terminal condition. First advocated by Louis Kutner in 1950,[6] a living will is a testamentary document, not unlike the more customary will used to dispose of property. If recognized as a legally enforceable instrument, the living will allows an individual by a prior act to outline the extent of his or her consent to medical treatment and, therefore, protects the individual's physician and hospital from any civil or criminal liability for failing to administer life-sustaining procedures to which the individual did not consent.

Effectuating the general purpose of the Bill, however, may not be easy. To do so, the Legislature must come to grips with a number of specific problems, including the need (i) to take reasonable steps to ensure that, when an individual sustains the terminal condition contemplated by his or her living will, the pre-existing document accurately reflected the intent of the individual at the time it was executed; (ii) to establish objective criteria for determining that the intentions expressed in the living will remain the intentions of the patient after the onset of the terminal condition; (iii) to establish criteria to ensure that the patient's intent is carried out; and (iv) to prevent outside influences from frustrating the purposes of the Bill. Each of these problems is discussed in greater detail below.

Although conceptually similar to previously considered Living Will legislation, the present Bill appears to enjoy renewed public support. . . .

Ensuring that the living will accurately reflects the individual's intent at the time of execution will require the Legislature to set forth formalities of execution that ensure the competency of the individual without becoming overly burdensome; it must also determine who, if anyone, will be responsible for determining if these formalities have been complied with. A testamentary will, for example, must be attested to by two witnesses and, upon the death of the individual making the will, filed with the appropriate probate court where the probate judge determines whether the formalities of execution have been complied with.

Developing objective criteria to determine whether the patient's intent as expressed in the living will remain his or her intent after the onset of a terminal condition will require the Legislature to consider the need to renew and the ability to revoke a living will. The Legislature must decide whether a living will should be regularly renewed (which, in essence, would require periodic affirmation by the declarant of his or her continuing intention that the living will remain viable), and whether, in the case of females, its terms should be suspended during the course of pregnancy. Moreover, the Legislature must provide methods by which the individual may revoke a living will — verbally, for example, or by non-verbal actions such as defacing or burning the document — and, if the individual must be competent to revoke the will, procedures by which the attending physician may determine whether the individual is competent.

Establishing objective criteria to ensure that the individual patient's intent is carried out will require the Legislature to consider the procedure for making the living will accessible to the attending physician as well as the definitions of terminal condition and life-sustaining procedures. The Legislature must detail where a living will is to be kept and how it is to be brought to the attention of the physician in order to minimize interference with the physician's ability to act quickly in administering (or withholding) treatment. Similarly, the Legislature must clearly define terminal condition and life-sustaining procedures in order to limit the scope of the living will.

Finally, preventing outside influences from frustrating the purpose of the Bill will require the Legislature to immunize from liability the actions of physicians who withhold or withdraw treatment pursuant to a living will and to protect the right of an individual who executes a living will to obtain and use insurance. The Bill forces physicians to make difficult decisions, such as certifying a patient's terminal condition. Therefore, to induce physicians to make those decisions, it must be expected that the Legislature will immunize the good faith actions of physicians (as well as hospitals, nurses, and others who implement physicians' decisions) from liability. The Legislature must also determine if the execution of a living will may inhibit or impair the sale, procurement, or issuance of any insurance policy, and whether the withholding or withdrawal of life-sustaining procedures pursuant to a living will may operate to deny additional insurance benefits for accidental death where the terminal condition was the result of an accident. Finally, it is expected that the Legislature will deal with the issue of whether the requesting of the withholding or withdrawal of life-sustaining procedure under the Bill could constitute a suicide.

Adoption by the Legislature of well drafted Living Will legislation would provide welcome relief both to individuals in Georgia desiring to avoid painful and expensive artificial medical procedures and to Georgia physicians treating terminal patients. Although the Legislature in the past has demonstrated its ability to adequately deal with the specific problems raised in drafting such legislation,[7] it has been unable to generate the votes required for passage. Nevertheless, given the increasing public support for Living Will legislation, this could be the year Georgia enacts a "Living Will" statute.

Notes

1. Vincent, 67 J. Med. A. Ga. 309, 309 (1978).

2. The first Living Will legislation considered by the Legislature appeared in House Bill No. 51 (titled A Natural Death Act) which was introduced in 1977. That bill died in the House Ecology Committee. Since 1977, the Legislature has considered Living Will legislation, in one form or another, at least four times.

3. Docket No. 83-6143 (DeKalb Cty. Super. Ct., Aug. 10, 1983).

4. *See* 14 Ala. Code §§ 22-8A-1 to -10 (1983) (The Alabama legislature adopted a bill titled A Natural Death Act in 1981.); 9 Del. Code Ann. tit. 16, §§ 2501-2509 (1982). (The Delaware legislature adopted a bill titled the Death with Dignity Act in 1982.); 4 D.C. Code Ann. §§ 6-2401 to -2430 (1983). (In 1982, the United States Congress adopted a bill titled the Uniform Determination of Death Act of 1981 on behalf of the District of Columbia.); and 6A Vt. Stat. Ann. tit. 25, §§ 5251 to 5262 (1983). (The Vermont legislature adopted Living Will legislation in 1982.)

5. The *Young* case involved a terminal patient with "Lou Gehrig's disease" who requested that he be taken off certain life support equipment. Because of the gravity of the patient's decision, the hospital chose to obtain a court order requiring that it withhold treatment. Following a request by the patient's family, a judge held a hearing at the patient's bedside; after convincing himself of the patient's competency, intent and condition, the judge ordered the hospital to disconnect the equipment. For further details on the *Young* case, see The Atlanta Journal/Constitution, August 7, 1983, at 1, col. 2.

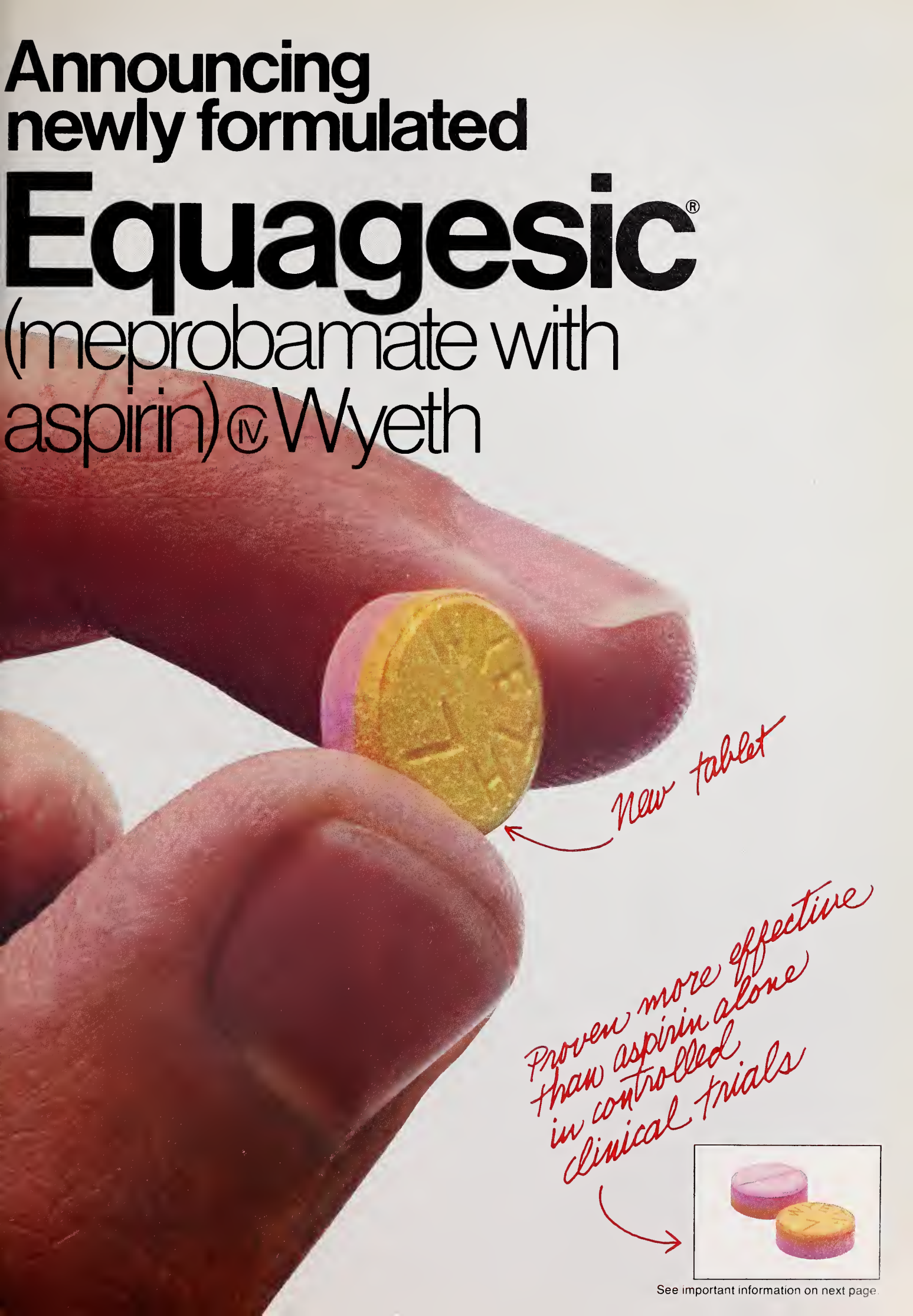
6. *See* Chicago Sun-Times, Nov. 16, 1975, at 59, col. 1.

7. Vincent, *supra* n.1, at 310.

Announcing newly formulated

Equagesic®

(meprobamate with aspirin) Ⓦ Wyeth



See important information on next page.

Equagesic®
(meprobamate with aspirin) © Wyeth

Effective adjunct in short-term treatment of pain
accompanied by tension and/or anxiety in patients with musculoskeletal disorders.



when anxiety magnifies the perception of pain



1-2 tablet dosage 3 or 4 times daily

Equagesic®
(meprobamate with aspirin) © Wyeth

(BRIEF SUMMARY)

DESCRIPTIDN:
Each tablet contains 200 mg meprobamate and 325 mg aspirin.

INDICATIONS:
Adjunct in short-term treatment of pain accompanied by tension and/or anxiety in patients with musculoskeletal disease. Clinical trials demonstrated that in these situations relief of pain is somewhat greater than with aspirin alone. Effectiveness in long-term use, i.e. over 4 months, has not been assessed by systematic clinical studies. Physicians should periodically reassess usefulness of drug for individual patients.

CDNTRAINDICATIDNS:
ASPIRIN: Allergic or idiosyncratic reactions to aspirin or related compounds.

MEPROBAMATE: Acute intermittent porphyria; allergic or idiosyncratic reactions to meprobamate or related compounds, e.g. carisoprodol, mebutamate, or carbromal.

WARNINGS:
ASPIRIN: Use salicylates with extreme caution in patients with peptic ulcer, asthma, coagulation abnormalities, hypoprothrombinemia, vitamin K deficiency, or those on anticoagulants. In rare instances, aspirin in persons allergic to salicylates may result in life-threatening allergic episodes.

MEPROBAMATE: DRUG DEPENDENCE: Physical and psychological dependence, and abuse have occurred. Chronic intoxication from prolonged ingestion of, usually, greater than recommended doses is manifested by ataxia, slurred speech, and vertigo. Therefore, carefully supervise dose and amounts prescribed and avoid prolonged use, especially in alcoholics and others with known propensity for taking excessive quantities of drugs. Sudden withdrawal after prolonged and excessive use may precipitate recurrence of preexisting symptoms, e.g. anxiety, anorexia, or insomnia, or withdrawal reactions, e.g., vomiting, ataxia, tremors, muscle twitching, confusional states, hallucinosis, and, rarely, convulsive seizures. Such seizures are more likely in persons with CNS damage or preexistent or latent convulsive disorders. Onset of withdrawal symptoms occurs usually within 12 to 48 hours after discontinuation; symptoms usually ceasa within next 12- to 48-hour period. When excessive dosage has continued for weeks or months, reduce dosage gradually over 1 to 2 weeks rather than stop abruptly. Alternatively, a short-acting barbiturate may be substituted, then gradually withdrawn.

POTENTIALLY HAZARDOUS TASKS: Warn patients meprobamate may impair mental or physical abilities required for potentially hazardous tasks, e.g., driving or operating machinery.

ADDITIVE EFFECTS: Since CNS-suppressant effects of meprobamate and alcohol or meprobamate and other psychotropic drugs may be additive, exercise caution with patients taking more than one of these agents simultaneously.

USAGE IN PREGNANCY AND LACTATION: An increesed risk of congenitel melformatione eesociatad with minor tranquillzers (meprobemete, chlordiezepoxide, and diazepem) during first trimester of pregnency, hae been euggaetad in severel studies. Because use of these drugs is rerely e mattar of urgency, their use during this period should almost elways be evoidad. The possibility that e women of childbearing potentiel mey be pregnent et time of inetitution of therapy should be considered. Advise petiante if they become pregnant during therapy or intand to becoma pregnant to communicata with their physiciene about deelrebility of discontinuing the drug.

Maprobamete passaa the plecentei barrier. It is present both in umbilicel-cord blood et or near meternel plasme levels and in breest milk of lactating mothers et concantretions two to four times thet of maternel plesme. When usa of meprobamate is contempleted in breastfeeding petients, consider tha drug's highar concentrations in braest milk as comperad to meternel pleeme levels.

USAGE IN CHILDREN: Keep preparations with aspirin out of reach of children. Equagesic® (meprobamate with aspirin) is not recommended for patients 12 years of age and under.

PRECAUTIONS:
ASPIRIN: Salicylates antagonize uricosuric activity of probenecid and sulfinpyrazone. Salicylates are reported to enhance hypoglycemic affect of sulfonylurea antidiabetics.

MEPROBAMATE: Use lowest effective dose, particularly in elderly and/or debilitated, to preclude over-sedation. Meprobamate is metabolized in the liver and excreted by the kidney; to avoid excess accumulation exercise caution in its use in patients with compromised liver or kidney function. Meprobamate occasionally may precipitate seizures in epileptic patients. It should be prescribed cautiously and in small quantities to patients with suicidal tendencies.

ADVERSE REACTIONS:
ASPIRIN: May cause epigastric discomfort, nausea, and vomiting. Hypersensitivity reactions, including urticaria, angioneurotic edama, purpura, asthma, and anaphylaxis may rarely occur. Patients receiving large doses of salicylates may develop tinnitus.

MEPROBAMATE: CNS: Drowsiness, ataxie, dizziness, slurred speech, headache, vertigo, weakness, paresthesias, impairment of visual accommodation, euphoria, overstimulation, paradoxical excitement, fast EEG activity.

GI: Nausea, vomiting, diarrhea.

CARDIOVASCULAR: Palpitation, tachycardie, various torms of arrhythmia, transient ECG changes, syncope, hypotensive crisis.

ALLERGIC OR IDIOSYNCRATIC: Milder reactions are characterized by itchy, urticarial, or erythematous maculopapuler rash, generalized or confined to the groin. Other reactions include leukopenia, ecute nonthrombocytopenic purpura, petechiae, ecchymoses, eosinophilia, peripheral edema, adenopathy, fever, fixed drug eruption with cross-reaction to carisoprodol, and cross-sensitivity between meprobamate/mebutamate and meprobamate carbromal. Rare, more severe hypersensitivity reactions include hyperpyrexia, chills, angioneurotic edema, bronchospasm, oliguria, and anuria. Also, anaphylaxis, exfoliative dermatitis, stomatitis, and proctitis. Stevens-Johnson syndrome and bullous dermatitis have occurred.

HEMATOLOGIC (SEE ALSO "ALLERGIC OR IDIOSYNCRATIC"): Agranulocytosis, aplastic anamia have been reported, although no causal relationship has been established, and thrombocytopenic purpura.

OTHER: Exacerbation of porphyric symptoms.

DOSAGE AND ADMINISTRATIDN:
Usual dose is one or two tablets, 3 to 4 times daily as needed for relief of pain when tension or anxiety is present. Not recommended for patients 12 years of age and under.

DVERDDSAGE:
Treatment is essentially symptomatic and supportive. Any drug remaining in the stomach should be removed. Induction of vomiting or gastric levage may be indicated. Activated charcoal may reduce absorption of both aspirin and meprobamate. Aspirin overdosage produces usual symptoms and signs of salicylate intoxication. Observation and treatment should include management of hyperthermia, specific parenteral electrolyte therapy for ketoacidosis and dehydration, watching for evidence of hemorrhagic manifestations due to hypoprothrombinemia which, if it occurs, usually requires whole-blood transfusions. Suicidal attempts with meprobamate have resulted in drowsiness, lethargy, stupor, ataxia, coma, shock, vasomotor and respiratory collapse. Some suicidal attempts have been fatal. The following data, reported in the literature and from other sources, are not expected to correlate with each case (considering factors such as individual susceptibility and length of time from ingestion to treatment), but represent usual ranges reported. Acute simple overdose (meprobamate alone): Death has been reported with ingestion of as little as 12 grams meprobamate and survival with as much as 40 grams.

BLOOD LEVELS:
0.5-2.0 mg percent represents usual blood-level renge of meprobamate after therapeutic doses. The level may occasionally be as high as 3.0 mg percent.

3-10 mg percent usually corresponds to findings of mild-to-moderate symptoms of overdosage, such as stupor or light coma.

10-20 mg percent usually corresponds to deeper coma, requiring more intensive treatment. Some fatalities occur.

At levels greater than 20 mg percent, more fatalities than survivals can be expected.

Acute combined overdose (meprobamate with other psychotropic drugs or alcohol): Since effects can be additive, history of ingestion of a low dose of meprobamate plus any of these compounds (or of a relatively low blood or tissue level) cannot be used as a prognostic indicator.

In cases of excessive doses, sleep ensues rapidly and blood pressure, pulse, and respiratory rates are reduced to basal levels. Any drug remaining in stomach should be removed and symptomatic treatment given. Should respiration or blood pressure become compromised, respiratory assistance, CNS stimulants, and pressor agents should be administered cautiously as indicated. Diuresis, osmotic (mannitol) diuresis, pentoneal dialysis, and hemodialysis have been used successfully in removing both aspirin and meprobamate. Alkalinization of the urine increases excretion of salicylates. Careful monitoring of urinary output is necessary, and caution should be taken to avoid overhydration. Relapse and death, after initial recovery, have been attributed to incomplete gastric emptying and delayed absorption.

HOW SUPPLIED:
Scored tablets, bottles of 100; Redipak® strip pack 25's; Redipak® unit dose 100's; individuelly wrapped.

CI 3343-1 9/6/83

Wyeth Laboratories
Philadelphia, Pa 19101

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NEW MEMBERS

Cook, John R., Richmond—ACT—D
Eisenhower Army Medical Center, Fort Gordon 30905

Ellison, Howard S., Newton-Rockdale—ACT—IM
1359 Milstead Rd., Conyers 30207

Gilmore, Thomas W., Jr., Jefferson—ACT—IM
1200 Peachtree St., Louisville 30434

Hixson, Jack D., Walker-Catoosa-Dade—ACT (N-2)—IM/PUD
Medical Plaza North, Ste. 504, Chattanooga, TN 37403

Martin, William D., Clayton-Fayette—ACT—OBG
29 Upper Riverdale Rd., Ste. 210, Riverdale 30274

Mersereau, John B., DeKalb—ACT—EM/FP
560 LaDonna Dr., Decatur 30032

Meyer, Roger A., DeKalb—ACT—MFS
1462 Clifton Rd., NE, Room 214, Atlanta 30322

Walker, Price, Jr., Muscogee—ACT (N2)—IM/HEM
P. O. Box 9516, Columbus 31908

PERSONALS

Second District

Archibald A. McNeill, M.D., of Camilla was elected Alternate Director of the Georgia Academy of Family Physicians for the second district, which encompasses an 18-county area of southwest Georgia.

William O. Brown, M.D., a pathologist, was elected chief of staff of the Colquitt County Memorial Hospital.

Third District

Americus physician, **Henry Teaford, M.D.,** was elected a Fellow in the American College of Chest Physicians.

Fourth District

Phillip R. Rogers, M.D., of Dunwoody, was elected to the Board of Directors of the Georgia Academy of Family Physicians from the 4th district.

Fifth District

Alex Klopman, M.D., of Roswell, was elected to serve as alternate director for the Georgia Academy of Family Physicians.

Atlanta physician, **P. McRae Temples, M.D.,** was elected President-elect of Charter Peachford Hospital.

Conway W. Hunter, Jr., M.D., of Atlanta, an authority on alcohol and drug addiction and formerly Corporate Medical Director of Charter Medical Corporation, has announced that he will concentrate on consultation, lecturing, writing and work with some of the professional and governmental bodies which he helps to direct. He is relocating to Sea Island but will still maintain an Atlanta office.

The newly formed Georgia Chapter of the American Association of Psychiatric Administrators, elected **Dave M. Davis, M.D.,** of Atlanta, as its president and **Michael A. Haberman, M.D.,** as its secretary-treasurer.

Douglas V. Jewson, M.D., has been named Director of Counterpoint Center of Parkwood Hospital, Parkwood's Chemical Dependency Program. Dr. Jewson is an internist and addictionologist. He was formerly the staff physician at Willingway Hospital in Statesboro.

Seventh District

Breman physician, **J. K. McLendon, M.D.,** was named by Governor Joe Frank Harris to Georgia's Health Planning Review Board.

Robert J. Alpern, M.D., was elected vice president of the newly formed Georgia Chapter of the American Association of Psychiatric Administrators.

Ninth District

Richard Wherry, M.D., of Dahlonega, was elected Alternate Director of the Georgia Academy of Family Physicians for the Ninth District.

SOCIETIES

Jeffrey T. Nugent, M.D., an Atlanta orthopedic surgeon, has been installed as president of the **Medical Association of Atlanta** for 1984, succeeding Bob G. Lanier, M.D. Dr. Nugent is a graduate of Emory University School of Medicine. He served his internship at Emory and Grady Hospitals, and his residency in orthopedic surgery at Johns Hopkins Hospital, Baltimore.



Jeffrey T. Nugent, M.D.



William H. Whaley, M.D. was elected president-elect. Dr. Whaley is a graduate of Dartmouth College and the Medical College of Georgia. He served his residency at Grady Memorial Hospital and specializes in hematology and oncology.

William H. Whaley, M.D.

J. Rhodes Haverty, M.D., was named recipient of the Aven Citizenship Cup, the Association's highest award for outstanding community service. Dr. Haverty is Dean of the School of Allied Health Sciences at Georgia State University. He was cited for his service to the Red Cross, the Atlanta Symphony, the Rotary Club, the Village of St. Joseph's, Trinity Presbyterian Church, Trinity School, and the Georgia Heart Association. Six members of the Association received certificates in recognition of 50 years in the practice of medicine. They are: *Louis Berger, M.D.; Lester A. Brown, M.D.; J. Harris Dew, M.D.; Guy C. Hewell, M.D.; Thomas F. Sellers, Sr., M.D.;* and *Amey Chappell, M.D.*

William E. Barfield, Sr., M.D., was elected president of the **Richmond County Medical Society for 1984.** Other officers elected include president-elect, *Edward H. Smith, M.D.;* vice president, *Albert A. Carr, M.D.;* and secretary treasurer, *Theodora Vanderzalm, M.D.*

Savannah physician, *Robert R. Quattlebaum, M.D.*, was installed as president of the **Georgia Medical Society.** Also installed as officers at the society's annual meeting were *J. Moultrie Lee, M.D.*, vice president; *Roderick L. Guerry, M.D.*, secretary; *Roland S. Summers, M.D.*, treasurer; *J. Patrick Evans, M.D.*, president-elect; *Dan H. Willoughby, M.D.*, parliamentarian; and *A. Preston Russell, M.D.*, historian.

SPECIALTY SOCIETIES

The Georgia Academy of Family Physicians, at its annual meeting in November, 1983, installed *John E. Fowler, M.D.*, as president. *David S. Sowell, M.D.*, was named chairman of the Board of Directors. Officers elected were *Andrew P. Morley, M.D.*, president-elect; *Larry Freeman, M.D.*, vice president; *John Baxley, M.D.*, vice speaker; and *Lanny Copeland, M.D.*, as Commission on Education. Andrew P. Morley, M.D., and Ollie McGahee, M.D., were named delegates and John E. Fowler, M.D., and Lanny Copeland, M.D., were named alternate delegates. *Keith Parmer, M.D.*, of Rome was awarded Family Practice Educator of the Year; and *Russell Hostetler, M.D.*, of Macon, was awarded Family Practice Resident of the Year. Certificates of Appreciation went to *John Aicher, M.D.*, Columbus; *Eugene Jackson, M.D.*, Moultrie; and *G. H. Perrow, M.D.* Jasper.



1984 GAFP Board of Directors

DEATHS

Arthur Nelson Berry

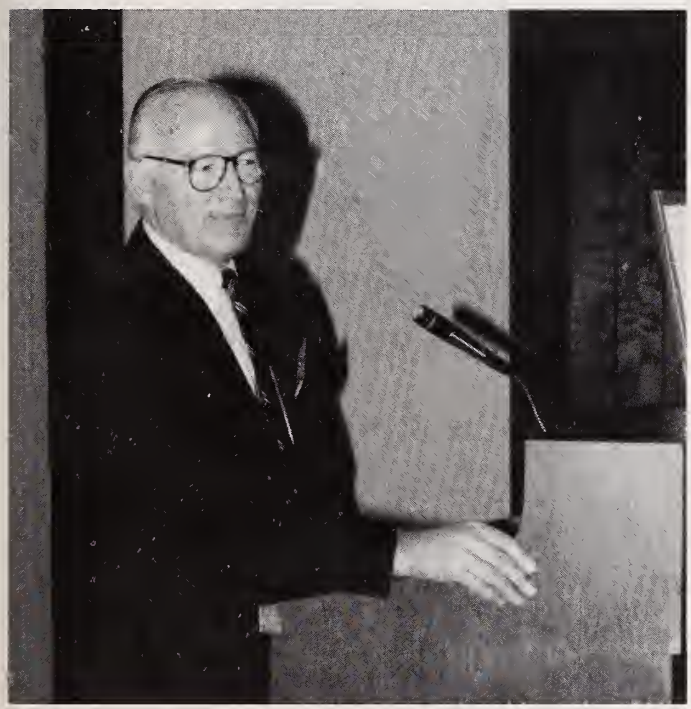
Arthur Nelson Berry, M.D., 79, a Columbus obstetrician and gynecologist and one of the founders of St. Francis Hospital, died December 9, 1983. Dr. Berry graduated from Harvard Medical School. He served in World War II as a major in the Medical Corps. He was a Fellow of the American College of Surgeons and a Fellow of the American College of Obstetrics and Gynecology. He was president of the Muscogee County Medical Society in 1942 and 1947. He was also a member of the South Atlantic Association of Obstetrics and Gynecology and the Southern Medical Association. Dr. Berry retired in 1971.

Survivors include his wife, one son, one daughter, one sister, one brother, and nine grandchildren.

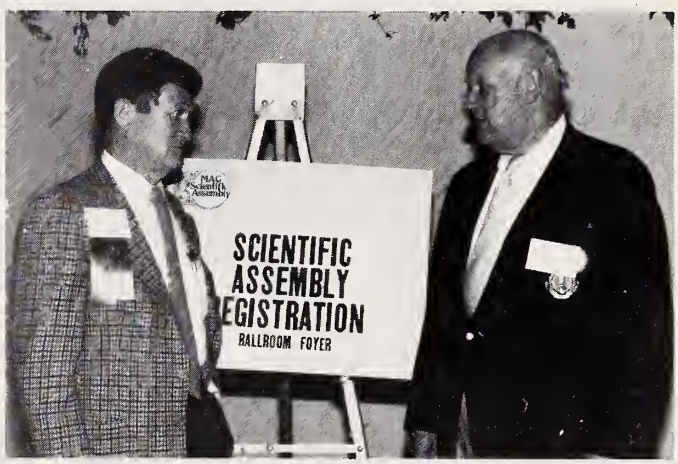
One of the benefits of the society meetings is their rich blend of guest faculty presentations and state society members' papers.

Another Successful Scientific Assembly

ELLIS B. KEENER, M.D., *Gainesville,* **and STEPHEN DAVIS,** *Atlanta**



Ellis B. Keener, M.D., addresses the Sunday meeting of the Georgia Neurosurgical Society devoted to socioeconomic issues. Dr. Keener, of Gainesville, chairs the MAG Committee on Scientific Assembly.



William W. Moore, Jr., M.D., President of the MAG, takes a moment to converse with William Huger, Jr., M.D., plastic surgeon from Atlanta.



On Sunday, Robert D. Collins, M.D. (left), of Vanderbilt, spoke at the meeting of the Atlanta Society of Pathologists. To his right is Dr. Jerry D. Porter, Program Chairman.

LAST NOVEMBER 18-20, the MAG again held its annual Scientific Assembly. Fifteen state specialty societies conducted medical education programs throughout the weekend, and they attracted over 700 physicians to the Colony Square Hotel in Atlanta.

A glance at the weekend suggests the variety of the scientific sessions. Highlighting Friday was

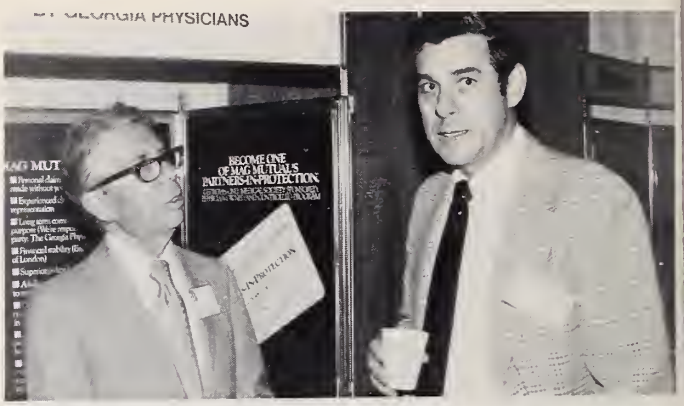
* Dr. Keener practices neurosurgery and is Chairman of MAG's Scientific Assembly Committee; Mr. Davis is Director of Education for the MAG.



Viewing "Sensations" at the new High Museum are Drs. Silas C. Read, Jr., of Athens; William H. Jarrett, II, of Atlanta; S. William Clark, Jr., of Waycross; James C. Joiner, III, of Decatur; and William S. Hagler, of Atlanta. The Georgia Society of Ophthalmology donated $3,000 for the exhibit.



Taking a break are (left to right), Drs. Timothy Harden, Jr., Earnest Atkins, Harrison Rogers, Jr., and Ellis Keener. Dr. Rogers is currently unopposed as candidate for the presidency of the American Medical Association.



The MAG Mutual Insurance Company was one of 30 exhibitors. Here, MAG Mutual marketing representative, Joseph D. Franco (left), talks with Nile R. Clark, M.D., family physician from Athens.

"Topics in Critical Care," which drew chest physicians, surgeons, and gastroenterologists. The Georgia Rheumatism Society, in cooperation with Syntex Laboratories, held a half-day session on "Managing the Arthritic Patient." Also meeting were allergists, otolaryngologists, and pediatricians.

One of the benefits of the society meetings is their rich blend of guest faculty presentations and state society members' papers. The American College of Surgeons and Georgia Society of Ophthalmology, for instance, devoted Saturday to members' papers. The Emergency Medicine meeting included a unique "hands-on" demonstration of techniques in plastic wound management. Other meetings on Saturday featured lectures for pulmonary critical care, neurology, neurosurgery, pathology, pediatrics, plastic surgery, and psychiatry.

On Sunday morning, November 20, the Atlanta Society of Pathologists held its annual slide seminar with Dr. Robert Collins of Vanderbilt speaking on "The Pathology of Aids." The Georgia Neurosurgical Society also held a session devoted to socioeconomic issues.

Social functions were part of the weekend, too, as several societies held luncheons and receptions. As part of their luncheon on Saturday, ophthalmologists got a chance to preview the new exhibit on "Sensations" at the High Museum of Art. The Medical College of Georgia alumni also gathered at the Cherokee Country Club, while the Georgia Chapter, American Academy of Pediatrics, held a "legislative" reception near the Capitol.

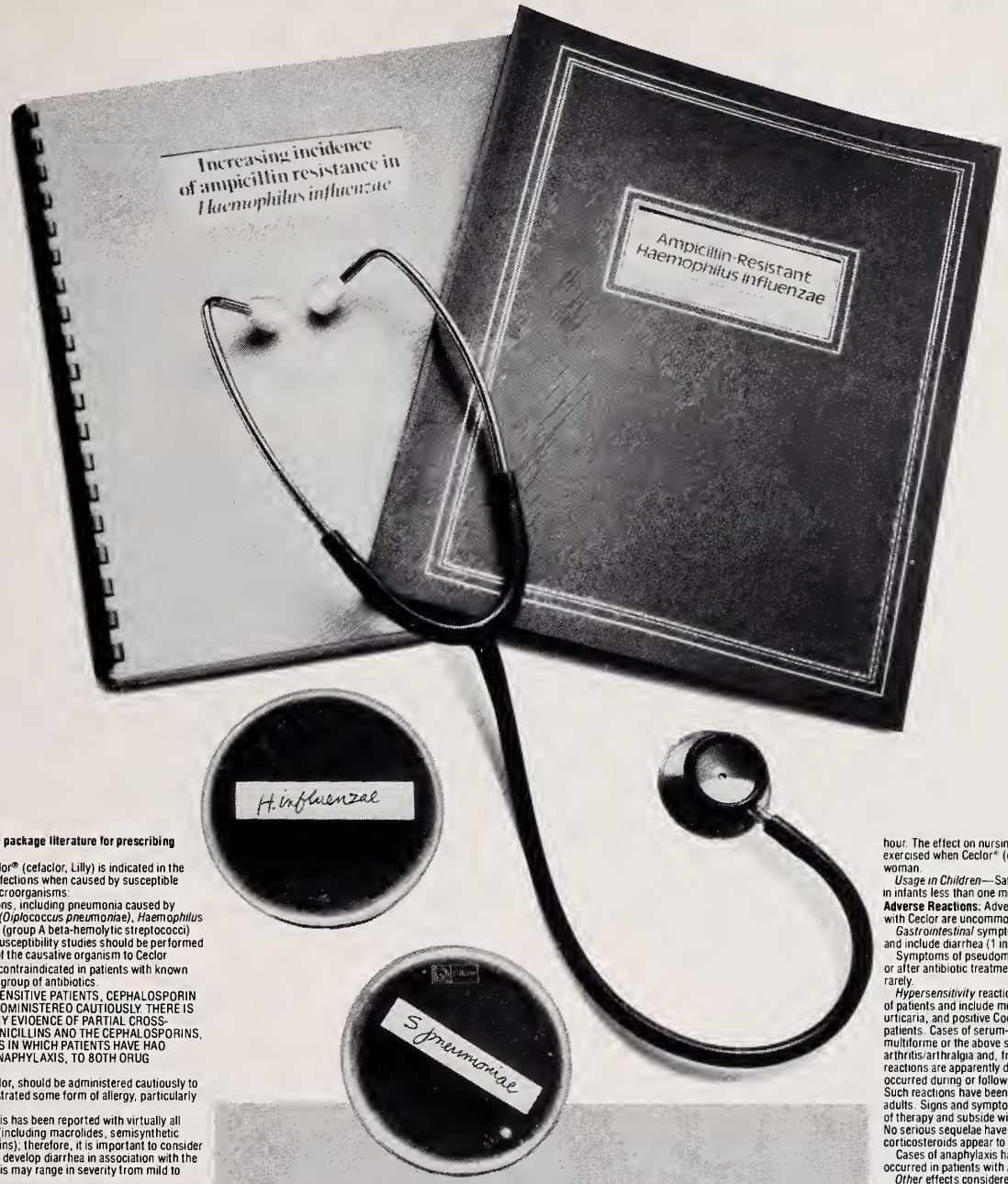
Over two dozen commercial and educational exhibits were on display in the Hotel's South Ballroom. Among them were booths for the MAG Mutual Insurance Company and for Milledgeville physician Dr. William Headley's exhibit on the gastric bypass operation.

The MAG assists participating societies by handling hotel arrangements, publicity, coffee breaks, audiovisual equipment, and registration. From the registration fees received, the Association reimburses societies for their speakers' expenses. These operations are supervised by the MAG Scientific Assembly Committee.

Plans for the 1984 Scientific Assembly are already underway. It will be held during November 16-18 at the Ritz-Carlton Buckhead Hotel in Atlanta, across from Lenox Square and Phipps Plaza. Once again we look forward to another successful Scientific Assembly, whose informal trademark has become:

Specialty societies come together.
MAG handles the details.
You get the rewards.

An added complication... in the treatment of bacterial bronchitis*



Some ampicillin-resistant strains of Haemophilus influenzae—a recognized complication of bacterial bronchitis*—are sensitive to treatment with Ceclor.[1-6]

In clinical trials, patients with bacterial bronchitis due to susceptible strains of Streptococcus pneumoniae, H. influenzae, S. pyogenes (group A beta-hemolytic streptococci), or multiple organisms achieved a satisfactory clinical response with Ceclor.[7]

Ceclor®
cefaclor

Pulvules®, 250 and 500 mg

Brief Summary. Consult the package literature for prescribing information.

Indications and Usage: Ceclor® (cefaclor, Lilly) is indicated in the treatment of the following infections when caused by susceptible strains of the designated microorganisms:

Lower respiratory infections, including pneumonia caused by *Streptococcus pneumoniae (Diplococcus pneumoniae), Haemophilus influenzae,* and *S. pyogenes* (group A beta-hemolytic streptococci)

Appropriate culture and susceptibility studies should be performed to determine susceptibility of the causative organism to Ceclor

Contraindication: Ceclor is contraindicated in patients with known allergy to the cephalosporin group of antibiotics.

Warnings: IN PENICILLIN-SENSITIVE PATIENTS, CEPHALOSPORIN ANTIBIOTICS SHOULD BE ADMINISTERED CAUTIOUSLY. THERE IS CLINICAL AND LABORATORY EVIDENCE OF PARTIAL CROSS-ALLERGENICITY OF THE PENICILLINS AND THE CEPHALOSPORINS, AND THERE ARE INSTANCES IN WHICH PATIENTS HAVE HAD REACTIONS, INCLUDING ANAPHYLAXIS, TO BOTH DRUG CLASSES

Antibiotics, including Ceclor, should be administered cautiously to any patient who has demonstrated some form of allergy, particularly to drugs.

Pseudomembranous colitis has been reported with virtually all broad-spectrum antibiotics (including macrolides, semisynthetic penicillins, and cephalosporins); therefore, it is important to consider its diagnosis in patients who develop diarrhea in association with the use of antibiotics. Such colitis may range in severity from mild to life-threatening.

Treatment with broad-spectrum antibiotics alters the normal flora of the colon and may permit overgrowth of clostridia. Studies indicate that a toxin produced by *Clostridium difficile* is one primary cause of antibiotic-associated colitis.

Mild cases of pseudomembranous colitis usually respond to drug discontinuance alone. In moderate to severe cases, management should include sigmoidoscopy, appropriate bacteriologic studies, and fluid, electrolyte, and protein supplementation. When the colitis does not improve after the drug has been discontinued, or when it is severe, oral vancomycin is the drug of choice for antibiotic-associated pseudomembranous colitis produced by *C. difficile*. Other causes of colitis should be ruled out.

Precautions: *General Precautions*—If an allergic reaction to Ceclor occurs, the drug should be discontinued, and, if necessary, the patient should be treated with appropriate agents, e.g., pressor amines, antihistamines, or corticosteroids.

Prolonged use of Ceclor may result in the overgrowth of nonsusceptible organisms. Careful observation of the patient is essential. If superinfection occurs during therapy, appropriate measures should be taken.

Positive direct Coombs' tests have been reported during treatment with the cephalosporin antibiotics. In hematologic studies or in transfusion cross-matching procedures when antiglobulin tests are performed on the minor side or in Coombs' testing of newborns whose mothers have received cephalosporin antibiotics before parturition, it should be recognized that a positive Coombs' test may be due to the drug.

Ceclor should be administered with caution in the presence of markedly impaired renal function. Under such conditions, careful clinical observation and laboratory studies should be made because safe dosage may be lower than that usually recommended.

As a result of administration of Ceclor, a false-positive reaction for glucose in the urine may occur. This has been observed with Benedict's and Fehling's solutions and also with Clinitest® tablets but not with Tes-Tape® (Glucose Enzymatic Test Strip, USP, Lilly).

Broad-spectrum antibiotics should be prescribed with caution in individuals with a history of gastrointestinal disease, particularly colitis.

Usage in Pregnancy—Pregnancy Category B—Reproduction studies have been performed in mice and rats at doses up to 12 times the human dose and in ferrets given three times the maximum human dose and have revealed no evidence of impaired fertility or harm to the fetus due to Ceclor. There are, however, no adequate and well-controlled studies in pregnant women. Because animal reproduction studies are not always predictive of human response, this drug should be used during pregnancy only if clearly needed.

Nursing Mothers—Small amounts of Ceclor have been detected in mother's milk following administration of single 500-mg doses. Average levels were 0.18, 0.20, 0.21, and 0.16 mcg/ml at two, three, four, and five hours respectively. Trace amounts were detected at one hour. The effect on nursing infants is not known. Caution should be exercised when Ceclor® (cefaclor, Lilly) is administered to a nursing woman.

Usage in Children—Safety and effectiveness of this product for use in infants less than one month of age have not been established.

Adverse Reactions: Adverse effects considered related to therapy with Ceclor are uncommon and are listed below.

Gastrointestinal symptoms occur in about 2.5 percent of patients and include diarrhea (1 in 70).

Symptoms of pseudomembranous colitis may appear either during or after antibiotic treatment. Nausea and vomiting have been reported rarely.

Hypersensitivity reactions have been reported in about 1.5 percent of patients and include morbilliform eruptions (1 in 100). Pruritus, urticaria, and positive Coombs' tests each occur in less than 1 in 200 patients. Cases of serum-sickness-like reactions (erythema multiforme or the above skin manifestations accompanied by arthritis/arthralgia and, frequently, fever) have been reported. These reactions are apparently due to hypersensitivity and have usually occurred during or following a second course of therapy with Ceclor. Such reactions have been reported more frequently in children than in adults. Signs and symptoms usually occur a few days after initiation of therapy and subside within a few days after cessation of therapy. No serious sequelae have been reported. Antihistamines and corticosteroids appear to enhance resolution of the syndrome.

Cases of anaphylaxis have been reported, half of which have occurred in patients with a history of penicillin allergy.

Other effects considered related to therapy included eosinophilia (1 in 50 patients) and genital pruritus or vaginitis (less than 1 in 100 patients).

Causal Relationship Uncertain—Transitory abnormalities in clinical laboratory test results have been reported. Although they were of uncertain etiology, they are listed below to serve as alerting information for the physician.

Hepatic—Slight elevations of SGOT, SGPT, or alkaline phosphatase values (1 in 40).

Hematopoietic—Transient fluctuations in leukocyte count, predominantly lymphocytosis occurring in infants and young children (1 in 40).

Renal—Slight elevations in BUN or serum creatinine (less than 1 in 500) or abnormal urinalysis (less than 1 in 200).

[061782R]

*Many authorities attribute acute infectious exacerbation of chronic bronchitis to either *S. pneumoniae* or *H. influenzae*.

Note: Ceclor is contraindicated in patients with known allergy to the cephalosporins and should be given cautiously to penicillin-allergic patients.

Penicillin is the usual drug of choice in the treatment and prevention of streptococcal infections, including the prophylaxis of rheumatic fever. See prescribing information.

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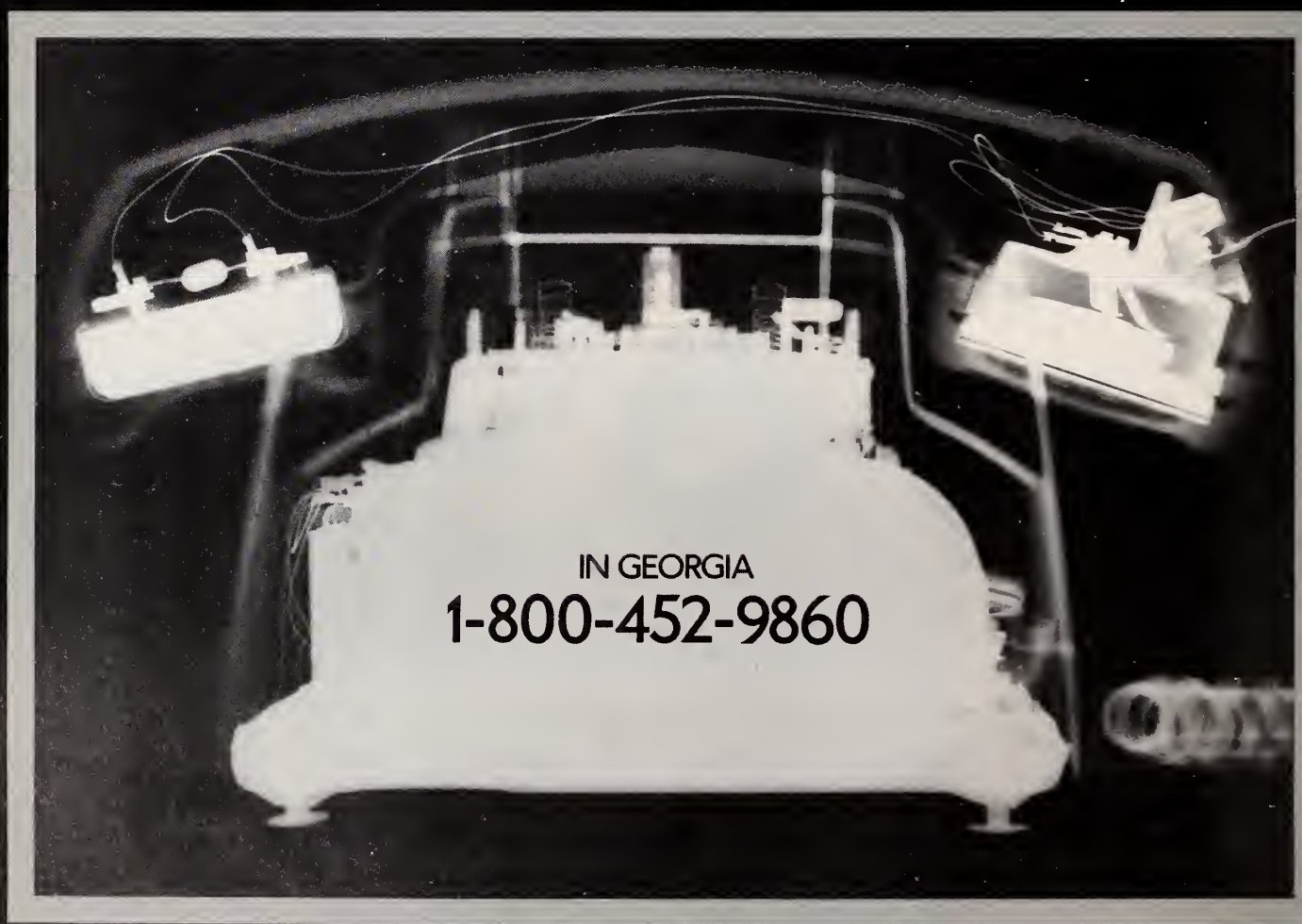
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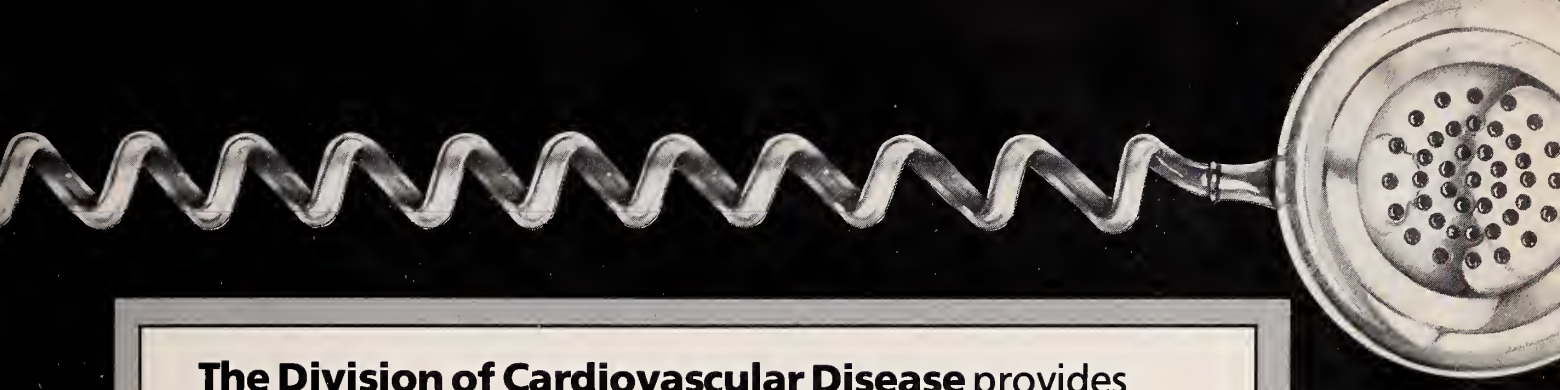
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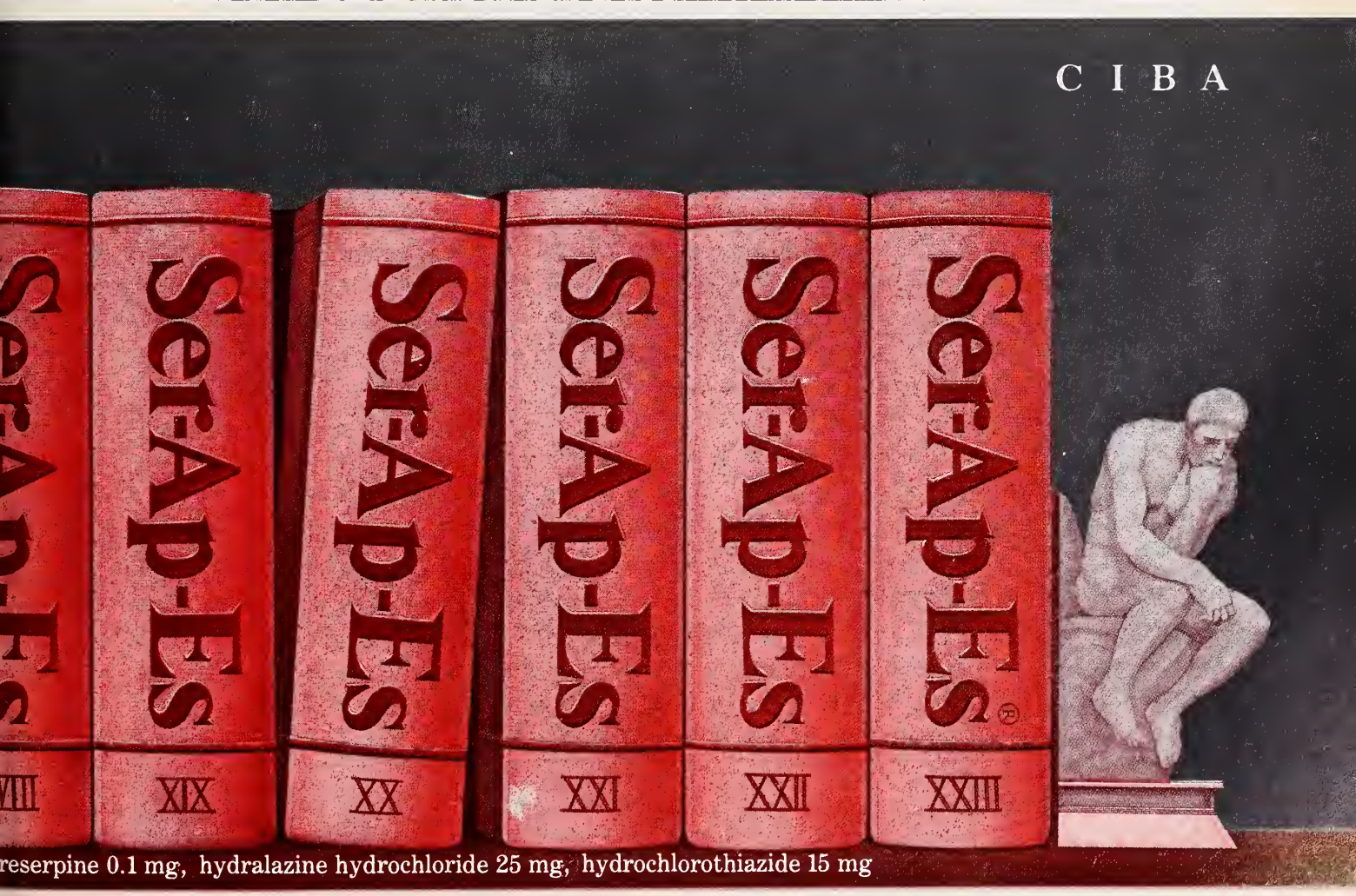
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> Soter NA, Wasserman SI, Austen KF. Cold urticaria release into circulation of histamine and eosinophil chemotactic factor of anaphylaxis during cold challenge. N Engl J Med 1976;294:687-90.

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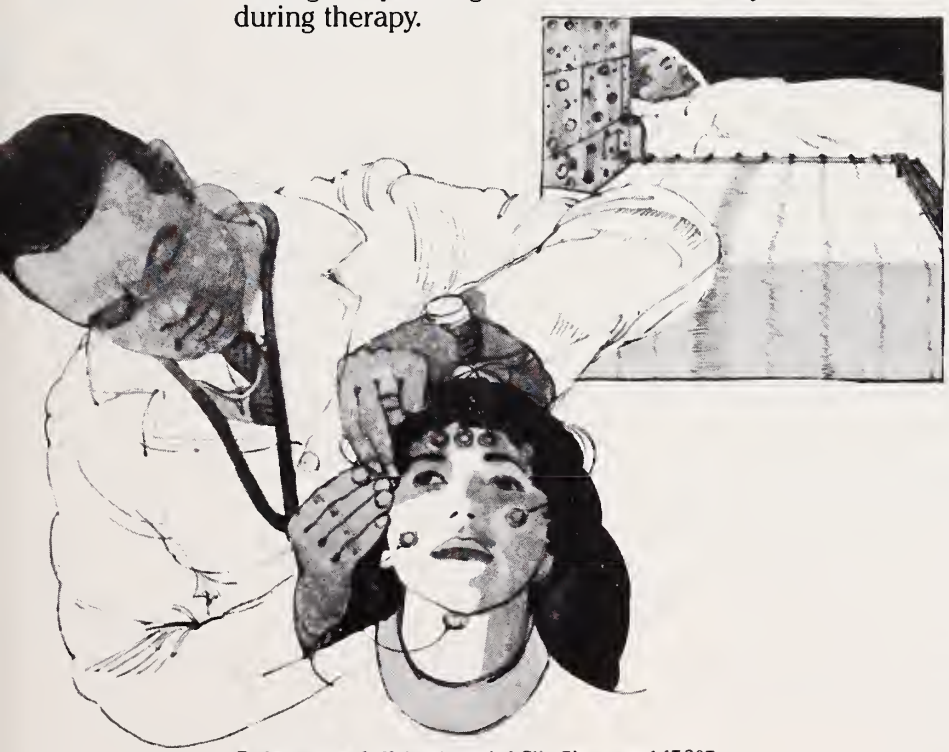
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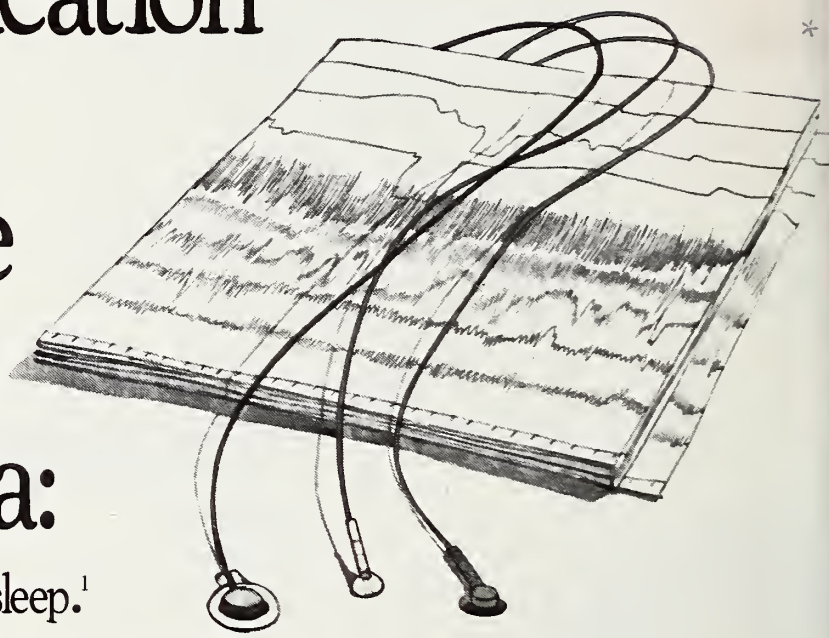
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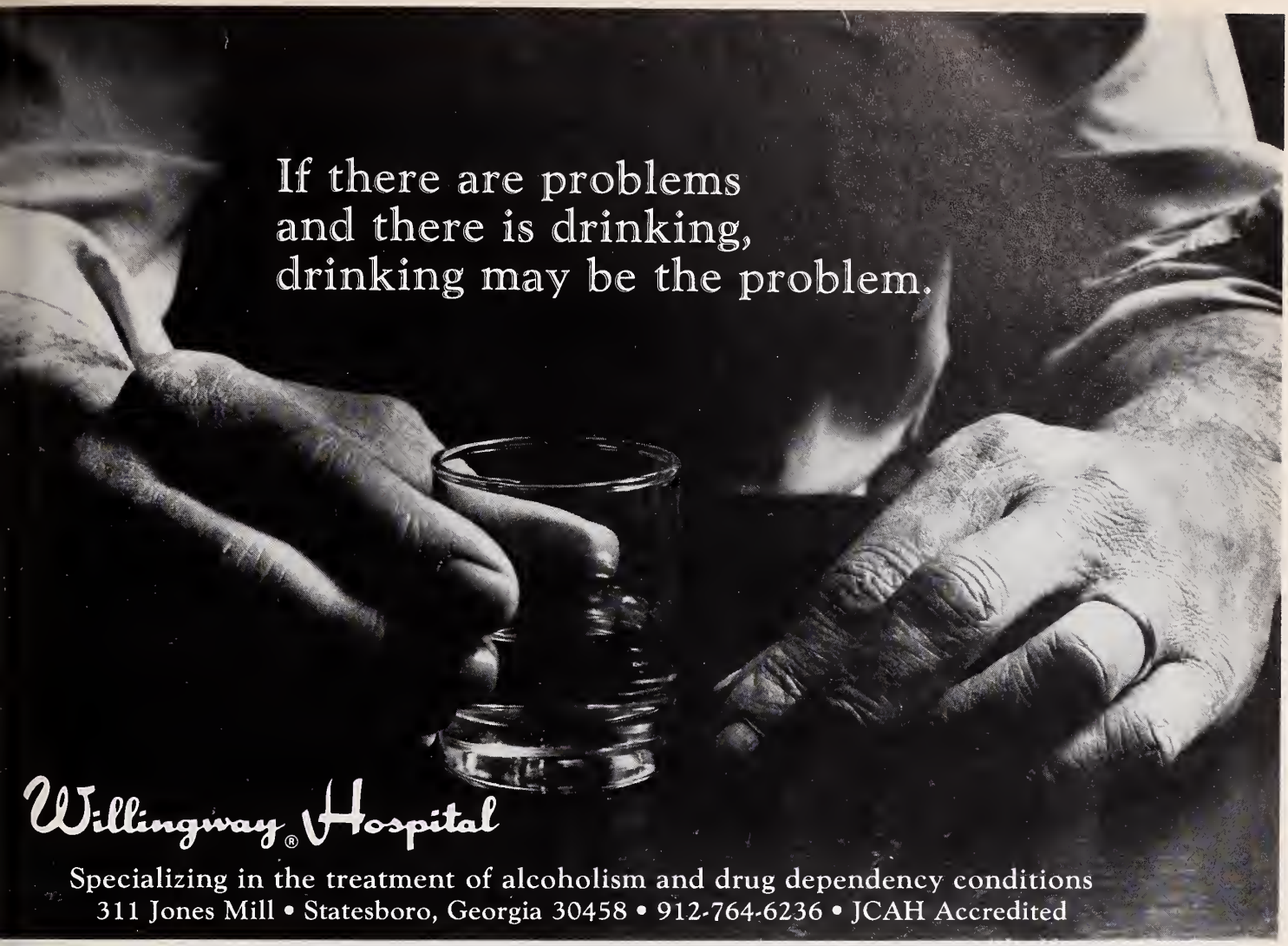
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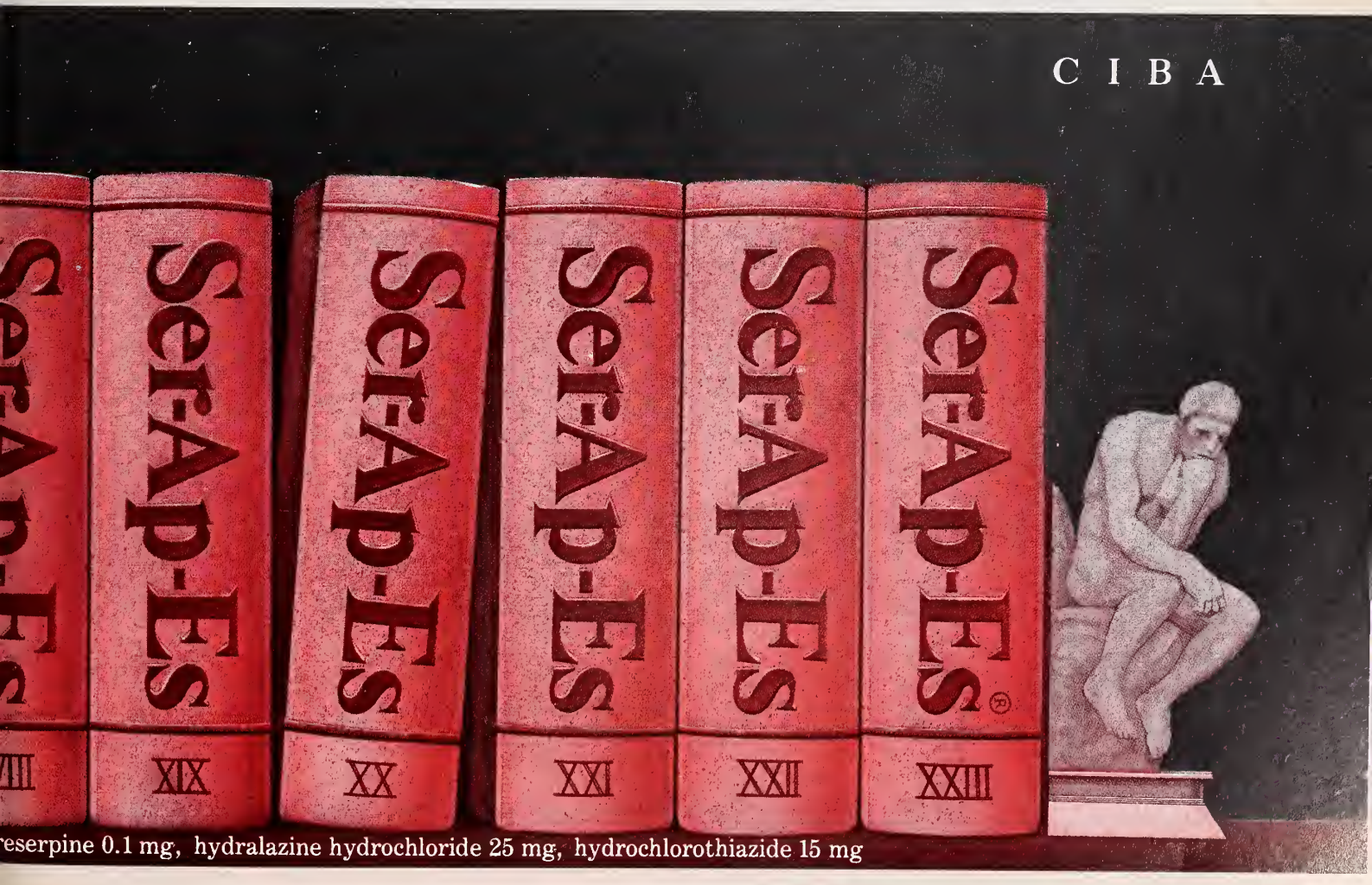
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The *Journal of the Medical Association of Georgia* is published monthly at 938 Peachtree Street, N. E., Atlanta, GA 30309-3990. Second-class postage paid at Atlanta, Georgia, and at additional mailing offices. POSTMASTER: Send address changes to Medical Association of Georgia, 938 Peachtree Street, N. E., Atlanta, GA 30309-3990.

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Featured speakers at the 19th annual Cobb County Symposium, co-sponsored by the Cobb County Medical Society and the Cobb County Medical Auxiliary are:

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Dr. John A. Scott, Director of the Gannett Foundation (which owns Channel 11), speaking at Kennesaw Friday morning;

Mr. Edwin Yoder, syndicated columnist;

Mr. Tom McKnight, President of Orion Tele-Communications, Ltd.; and

Dr. Jonas Salk, who will speak on Friday evening.

A reception will be held for Dr. Salk at the Northwest Marriott Hotel in Cobb County at 5:30 with a dinner following. His address will be given at the Roswell Street Baptist Church in Marietta at 8:15 p.m. The only charge for the Symposium is for the Friday night dinner, $25 per person, and for admission to Dr. Salk's talk, $4, purchased at the door. For further information, please call Kennesaw College, 429-2958.

Physician Involvement Program (PIP)

To ensure the success of its legislative program, *MAG needs your active involvement.* MAG is, for the fourth year, sponsoring the Physician Involvement Program (PIP). The goal of this program is to have at least ten physicians per day attend a session of the General Assembly. You must be there to tell your legislators how their actions will affect you, your practice, and your patients.

Each session begins at 8:30 a.m. with coffee and a briefing at the Stadium Motel which is located at Howard Johnson's on Washington St., S.W., 4 blocks from the Capitol. The briefing session includes an explanation of how legislation is introduced, considered in committee, and voted on by each house. The briefing also includes a summary of legislation that MAG is tracking and an explanation of any bills that will be considered that day.

At approximately 9:45, the participants go to the Capitol by shuttle bus so each physician will have the opportunity to meet his legislators. The rest of the day is free to observe the Senate and House in session or attend any committee meetings or hearings of interest. MAG staff is available to assist you.

To get involved in this program, please call MAG at 876-7535 or toll free 1/800-282-0224. Your help is needed! Please volunteer.

FTC Study Hits Ophthalmologists

Opticians can fit contact lenses as well as ophthalmologists, at a lower cost to the consumer, according to a new Federal Trade Commission report. But the report has come under fire by ophthalmologists, who fear that its widespread acceptance could harm patients who need the medical suspension of a physician.

This finding, if accepted by FTC commissioners, could result in a loosening of restrictions on the business practices of opticians. An earlier but similar FTC report on eye glasses and eye examinations has become the basis for a new FTC rulemaking.

The FTC study said there is little differnce in the quality of contact lens fitting performed by opticians, optometrists, and ophthalmologists. The majority of 500 contact lens wearers from 18 cities, when interviewed and examined, were found to have healthy eyes and well-fitting contacts. Only a handful of patients had serious ocular abnormalities; of these, most did not relate to contact lens wear.

There was a wide range in costs, however. The average price for lenses, including examination, ranged from $119 to $183 for hard lenses and from $150 to $234 for soft lenses. The FTC said that ophthalmologists were the most expensive, commercial optometrists were the least expensive, and opticians and non-commercial optometrists charged prices somewhere in between.

"The findings call into question claims that restrictions on contact lens fitting by non-physicians are necessary to protect the public," according to the report. Such restrictions may increase costs to consumers by limiting the choices available to them and reducing competition in the marketplace, the report adds.

Some states forbid opticians to fit lenses, while others permit opticians to fit lenses only under the supervision of an ophthalmologist or optometrist. In the remaining states, the restrictions are fuzzy; state courts have reached differing opinions.

Physicians dispute both the methodology and the conclusions of the study. Only an ophthalmologist has the medical training to handle complications or hard-to-fit patients, says the American Academy of Ophthalmology. Since the FTC questioned only persons who were wearing contacts at the time, it may have overlooked difficult cases, such as persons with unusual eye structure or pathology. An eyeglass wearer reading the report has no way of knowing if he is a problem-free lens wearer or if he may encounter difficulties, says the physicians group.

Americans Are Healthier — For a Price

Americans are healthier than ever, according to the annual report, "Health United States," released by the U.S. Department of Health and Human Services in January. But the price tag for health care services also continues to climb, outstripping inflation, the report shows.

Health Status

* After a temporary decline after the 1980 flu epidemic, American life expectancy has resumed its upward trend. Women born in 1982 can expect to live to age 78.2 years, up from 77.9 years in 1981. Men will live an average of 70.8 years, up from 70.3 in 1981.

* Infant mortality continues to decline, reaching 11.2 deaths per 1,000 live births, down from 11.7 deaths in 1981. But the mortality rate for black infants remains almost twice as high as for whites.

* Fertility climbed in the late 1970s, reversing the plummet of birth rates seen in the early part of the decade. Yet it is far from the proportions of the "baby boom" of the 1950s. There were 15.9 births per 1000 population in 1980, compared to 25.0 births per 1000 population in 1955. The average number of births expected by women 18-34 years of age has decreased during the past decade from 2.6 in 1971 to 2.2 in 1980.

* Cardiovascular disease and cerebrovascular disease claimed fewer lives in 1982 than in 1981, from 196 to 190 deaths per 100,000 population and 38 to 36 deaths per 100,000 population, respectively. Malignant neoplasms have increased, however, from 131 to 133 deaths per 100,000 population between 1981 and 1982.

Health Care Expenditures

* In 1982, health care expenditures in the United States totalled $322.4 billion, an average of $1,365 per person, and comprised 10.5% of the gross national product. By comparison, 1981 health care expenditures totalled $286.6 billion, an average of $1,225 per person, and comprised 9.8% of the gross national product.

* Medical care prices continued to increase above and beyond the inflation rate, the report said. Between 1981 and 1982, medical care prices grew 11.6%, compared to a 6.1% increase in the Consumer Price Index. In the prior year, medical care prices grew 10.8%, compared to a 10% increase in the overall index.

* Hospital care expenditures continue to claim the largest share of the health care dollar; 42% of all expenditures in 1982. Physician services, dentist services, and nursing home care accounted for 19%, 6%, and 9%, respectively.

Utilization of Health Care Resources

* Cardiac catheterization among middle-aged and elderly men continues to increase rapidly. Between 1979 and 1981, cardiac catheterization increased 97% for men over age 65 and 34% for men aged 45-64. Coronary bypass surgery increased 27% for younger men and 89% for men over age 65.

* CAT scans among hospitalized persons doubled between 1979 and 1981, from 0.8 to 1.8 per 1000 persons in all age and sex groups.

* Diagnostic ultrasound among hospitalized women increased 91% between 1979 and 1981. The increase was particularly dramatic — 126% — in women over age 65.

* Lens extraction among the elderly increased 30% between 1979 and 1981. Furthermore, 57% of these procedures were accompanied by the insertion of a prosthetic lens in 1981, compared with 36% in 1979.

Health Care Resources

* The proportion of women among graduates of health professions' schools has increased steadily since the 1960s. The proportion of female medical school graduates jumped from 5% in 1955 to 23% in 1980.

* Compared to voluntary hospitals, both urban and rural public hospitals had higher newborn death rates and a greater incidence of low-birth-weight infants.

* In metropolitan areas, public hospitals treated more miniority patients than voluntary hospitals (20% vs. 11%), more Medicaid patients (15% vs. 8%), and more uninsured patients (12% vs. 6%).

Hospitals Win/Lose Under Final DRGs

Hospitals got several things they asked for in the final regulations for Medicare's new fixed-price payment system, but they will have to live with a $24 million reduction in reimbursement next year.

The final regulations for the Diagnosis Related Groups (DRGs) published in the Federal Register January 3 offer several important changes in the regulations in effect since October 1. The new rules are expected to cut Medicare payments to hospitals by more than $100 million a year after 1986.

Hospitals generally were pleased with changes that loosen the criteria for exemptions from DRGs for certain types of hospitals, that permit hospitals to charge Medicare patients for requested services the hospital and physician have found unnecessary, and modify the calculation of payments for unusually lengthy or costly cases. Some physician groups, including the AMA, commended HCFA for modifications relating to indirect medical education costs, but they reiterated their opposition to the "radical restructuring" of the health care system under DRGs.

Both hospitals and physician groups are unhappy about an OMB-instigated modification that hospital experts predict will reduce the payment per Medicare case by $9 to $13 and decrease total Medicare payments to hospitals by $24 million next year. The diminished payments result from a decrease in the inflation update for DRG rates from the 11.7% published in the interim regulations to 10.9% in the final regulations.

Though critical of the precedent set by the reduction in the inflation factor, hospital officials say its initial impact is outweighed by their success in renegotiating the way DRG payments are calculated for outlier cases that exceed normal lengths of stay or are unusually costly. In effect, the change means that during the transition to a totally national DRG rate, hospitals will be paid somewhat more for the bulk of their cases but will receive less for outlier cases than under the interim regulations.

Letters to the Editor . . .

One Physician's Experience with Freestanding Emergency Clinics

Dear Sir,

I am writing concerning the article in the January issue of the *Journal* concerning Freestanding Emergency Clinics. I was particularly interested in the statements made by Mr. John Carpenter, President of Candler General Hospital and Sister Mary Faith, R.S.M., President of St. Joseph's Hospital in Savannah. I feel I am uniquely qualified to comment after having been the Medical Director of the Emergency Department at Candler General and having been a member of the Emergency Department staff at St. Joseph's. Mr. Carpenter's statement concerning costs made me laugh. This was because I resigned my very lucrative and enjoyable position after eleven years of work at Candler General Hospital because of what I considered to be excessive patient charges after the hospital moved to its new $46,000,000 facility. Prior to building the new hospital I was involved in the design and development of the new Emergency Department. Of the nine rooms in that department only two "are geared for really traumatic sorts of situations," one is for acute cardiac problems, and the remaining six are used for the treatment of minor illnesses. Mr. Carpenter also did not mention the fact that the emergency department physicians at the hospital have recently opened an FEC financed by the Lamara Corporation — an entity wholly owned by Candler General Hospital. As anyone can see, Candler General Hospital and its President would naturally support an FEC as a source of both in-patients and out-patients.

I must agree with Sister Mary Faith in her interpretation of the problem a patient faces in going to an FEC. Presently I am the Medical Director of the busiest emergency department of the largest hospital in Mississippi. My colleagues are all board certified or board eligible. We all agree that working in an FEC would be quite boring and professionally unfulfilling. This would eventually lead to a decrease in a physician's concern for his patients and complacency in his level of diagnostic acumen. My experience with non-hospital affiliated FECs has been that the physicians employed by the FEC fall into two categories — the older physician who wishes to decrease his professional responsibilities or the young physician who is still building his practice and wishes to supplement his income. Only time will tell if the level of care rendered by FECs will approach that in a hospital emergency department staffed by dedicated full time emergency physicians.

Sincerely,
Alan P. Brown, MD, FACEP
Tupelo, Mississippi

In Praise of "A Medical Revolution"

Dear Sir:

I was most pleased to read the excellent editorial written by Dr. Harrison Rogers entitled, "A Medical Revolution," in the December issue of the *Journal*. This is a very clear, concise, and realistic look at the practice of medicine in the U.S. today. The road ahead is not smooth, the picture not pretty, and the future not clear. One thing is certain, however, we are all in this together, patient and physician. It will take all our combined wisdom and concerted effort to solve our problems.

I am fundamentally optimistic, but this is primarily because I have faith in the capacity of the generations that follow us to solve the problems that are so threatening to us — not because I see any easy or quick solutions, for there aren't any.

We are fortunate to have members of our profession such as Dr. Rogers who are knowledgeable and articulate and who will take the time and make the effort to lead us in these times.

I wish to thank him again for the job he is doing.

Most sincerely,
Thomas E. Reeve, Jr., M.D.
General and Vascular Surgeon
Carrollton

Feedback on MAG Leadership Conference

Dear Sir:

I have attended both of the leadership conferences promoted by the Medical Association of Georgia and wish to commend those responsible for developing these most worthwhile programs. I wish to make a few personal observations regarding the most recent one at the Waverly Hotel [in Atlanta]. I am distressed to report that, in my opinion, the participants came very close to signing the death knell for fee-for-service, traditional personalized health care delivery that we all cherish. Hopefully, that was not the intent or design of the MAG leadership, but rather was the tenor set by most of the speakers.

I am well aware of what is going on in other sections of this country and constantly monitor the changes in metro Atlanta in regard to the many varied alternative health care delivery mechanisms creeping onto the scene. At present, most of these elements are currently active and obvious in Georgia only in and around the metro areas. If a poll were taken of the MAG membership, I am certain that an overwhelming majority would agree that: a) we have the best health care delivery system in the world; b) the best, most personal, health care is delivered by a carefully chosen private physician; and c) that fee-for-service is a more desirable means of remuneration than pre-paid plans and can (and should) be more cost effective. Further, I believe, a somewhat smaller majority would like to see the MAG leadership develop a *strong marketing program* to promote the above.

We have a good product, why can't we get about the job of selling it? We know what the problems are; we know where the voids are; we know what consumers are justly complaining about; and, further, we must know what has to be done in order to turn the tide. Very simply, we must provide the *highest quality* of medical care at a *reasonable cost*. We must be considerate of the patient's time and convenience. We must further be concerned about the proper utilization of hospital facilities and the costs thereof.

There is precious little time left, but I personally feel that the private practice of medicine can yet be salvaged. It would be tragic if we don't mount an all out effort to fight for "survival in the market place" and then see the eighties bring down the curtain on this great bastion of free enterprise.

Sincerely,
Ralph A. Tillman, M.D.
Ob/Gyn, Atlanta

MEDICAL MEETING CALENDAR

MARCH

16 — *Columbus:* **Carcinoma of the Genitourinary System and Non-Hodgkins Lymphoma.** Category 1 credit. Contact Julian Duttera, M.D., Clark-Holder Clinic, 303 Smith St., LaGrange 30240. PH:404/882-8831.

16 — *Savannah:* **Day of Cancer.** Sponsored by Ga. Div., American Cancer Society. Category 1 credit. Contact James Scott, M.D., 9-A Med. Arts Ctr., Savannah 31405. PH:912/354-2108.

23-24 — *Savannah:* **MAG Risk Management Seminar.** Category 1 credit. Contact Ms. CaRita Connor, Ga. Med. Soc., P.O. Box 5716, Savannah 31404. PH:912/355-6607.

29 — *Columbus:* **Critical Care Medicine for the Primary Care Physicians.** Category 1 and AAFP prescribed credits. Contact Judy Anderson, Internal Med. Found., P.O. Box 311, Columbus 31902. PH:404/571-1454.

29-30 — *Atlanta:* **American Society for GI Endoscopy — Training Directors Workshop.** Contact Am. Soc. for Gastrointestinal Endoscopy, 13 Elm St., Manchester, MA 01944.

APRIL

2-3 — *Atlanta:* **Nutrition, Eating, and Behavior.** Contact Ann Robinson, Coll. of Health Sciences, Box 873, Ga. State Univ., Atlanta 30303. PH:404/658-3085.

4-6 — *Atlanta:* **Techniques in Orthopaedic Surgery.** Category 1 credit. Contact Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., NE, Atlanta 30322. PH:404/329-5695.

5-7 — *Marietta:* **Cobb County Symposium — "The Human Prospect — 1984 Revisited."** Contact Cont. Ed. Dept., Kennesaw College, Marietta 30062. PH:404/429-2958.

5-7 — *Atlanta:* **Introduction Into Percutaneous Transluminal Angioplasty III.** Category 1 credit. Contact Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., NE, Atlanta 30322. PH:404/329-5695.

6-7 — *Callaway Gardens:* **4th Annual Geriatric Conference For Primary Physicians.** Category 1 credit. Contact Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., NE, Atlanta 30322. PH:404/329-5695.

8-12 — *Atlanta:* **American Association of Neurological Surgeons.** Contact AANS, 625 N. Michigan Ave., Ste. 1519, Chicago, IL 60611. PH:213/944-4205.

9-12 — *Atlanta:* **Demonstration In Percutaneous Transluminal Angioplasty XI.** Category 1 credit. Contact Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., NE, Atlanta 30322. PH:404/329-5695.

12-14 — *Atlanta:* **Pharmacology for the Anesthesiologist.** Category 1 credit. Contact Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., NE, Atlanta 30322. PH:404/329-5695.

13 — *Atlanta:* **7th Annual Metabolic Support Seminar: Practical Aspects of Computers, Branch Chain Amino Acids, Cost Effectiveness, and Home Nutrition Company Selection.** Category 1 credit. Contact Beverly Palabinett, Georgia Bapt. Med. Ctr., 300 Blvd., NE, Atlanta 30312. PH:404/653-4496.

14 — *Atlanta:* **DRGs in the 80s.** Contact Amer. Coll. of Utilization Review Physicians, 1108 N. Second St., Harrisburg, PA 17102.

14-15 — *Atlanta:* **The Cardiac Patient: Management for Cardiopulmonary Bypass.** Category 1 credit. Contact Dir., Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., NE, Atlanta 30322. PH:404/329-5696.

16-18 — *Atlanta:* **Pediatric Infectious Diseases and Immunology.** Category 1 credit. Contact Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., NE, Atlanta 30322. PH:404/329-5695.

26-29 — *Atlanta:* **MAG House of Delegates.** Contact J. Tom Sawyer, MAG, 938 Peachtree St., NE, Atlanta 30309. PH:404/876-7535 or 800-282-0224 (toll free in Ga.)

26-29 — *Atlanta:* **American College of Physicians.** Contact ACP, 4200 Pine St., Philadelphia, PA 19104. PH:215/243-1200.

27-28 — *Augusta:* **Ocular Toxicology.** Category 1 credit. Contact Div. of Cont. Ed., MCG, Augusta 30912. PH:404/828-3967.

27-29 — *Atlanta:* **Advanced Cardiovascular Diagnostic, Therapeutic, Rehabilitation, and Patient Follow-Up Methods.** AMA Category 1 and AAFP prescribed credits. Contact International Med. Educ. Corp., 64 Inverness Dr. E., Englewood, CO 80112. PH:800/525-8651.

27-29 — *Atlanta:* **Health By Choice.** Contact Bonnie H. Lawson, Ph.D., Georgia Center for Continuing Education, Univ. of Ga., Athens 30601. PH:404/542-7553.

30-May 3 — *Callaway Gardens:* **Acute Injuries to the Knee.** Contact American Acad. of Orthopaedic Surgeons, 444 N. Michigan Ave., 15th Fl., Chicago, IL 60611.

30-May 5 — *Augusta:* **19th Annual Family Practice Symposium.** AMA Category 1 and AAFP prescribed credit. Contact Div. of Cont. Educ., MCG, Augusta 30912. PH:404/828-3967.

MAY

3-4 — *Atlanta:* **TUR.** Contact Merrily Laube, Southern Foundation for Edu. and Medical Research, Inc., 98 Currier St., Atlanta 30303. PH:404/688-3323.

3-6 — *Sea Island:* **Georgia Society of Ophthalmology.** Category 1 credit. Contact Talitha Russell, 938 Peachtree St., NE, Atlanta 30309. PH:404/876-7535 or 1-800-282-0224 (toll free in Ga.).

10-11 — *Columbus:* **Twelfth Annual Perinatal Medicine Conference.** Category 1 credit. Contact Div. of Perinatology, The Medical Center, P.O. Box 951, Columbus 31994. PH:404/324-4711.

10-12 — *Macon:* **Conflicts with Newborns: Saving Lives, Scarce Resources, and Euthanasia.** Category 1 credit. Contact Prof. Richard McMillan, Mercer Univ. Sch. of Med., Rm E-61, Macon 31207. PH:912/744-4045.

11-12 — *Atlanta:* **3rd Annual Update of the Diagnosis and Treatment of Lupus Erythematosus.** Category 1 credit. Contact Stephen Balch, M.D., Dir., Jacquelyn McClure Lupus Treatment Ctr., 3200 Howell Mill Rd., NW, Atlanta 30324. PH:404/351-0351.

18 — *Atlanta:* **Childhood Arthritis Update.** Category 1 credit. Contact Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., NE, Atlanta 30322. PH:404/329-5695.

18-20 — *Augusta:* **Allergy and Immunology — Recent Advances.** Category 1 credit. Contact Div. of Cont. Ed., MCG, Augusta 30912. PH:404/828-3967.

30-June 2 — *Hilton Head, SC:* **American Academy of Clinical Anesthesiologists Spring Seminar.** Category 1 credit. Contact Donald Catron, M.D., Program Director, AACA, P.O. Box 11691, Knoxville, TN 37939-1681. PH:615/588-6279.

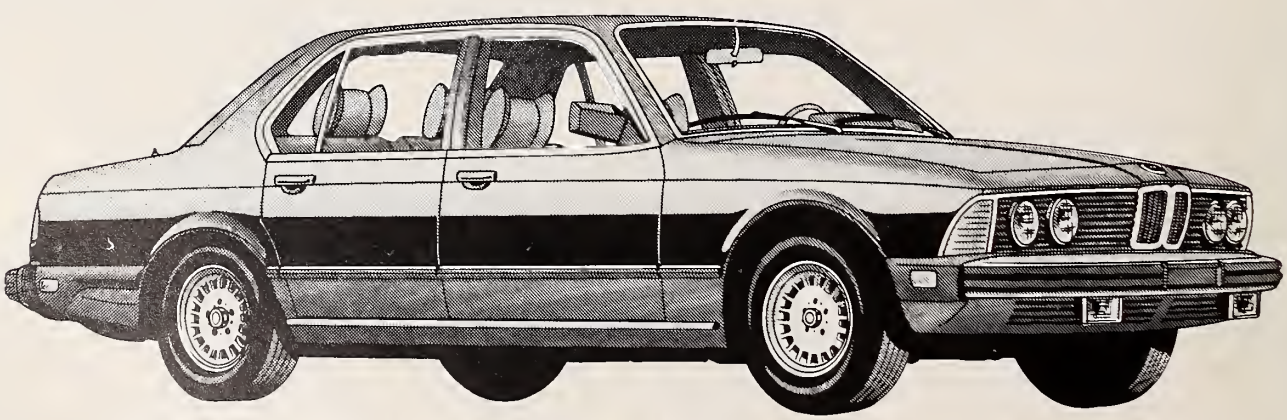
31 — *Valdosta:* **Cardiovascular Risk Factors in Children.** Category 1 credit. Contact Sandra Owen, Ga. Affil., American Heart Assn., Box 13589, Atlanta 30324. PH:404/261-2260.

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editorials
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Are We Good "Doctors' Spouses"?



Evelyn Ward Gay

SINCE THE FIRST SPECIAL Auxiliary issue of the *Journal of the MAG* was published in February of 1983, long-standing programs of value have been continued, many new projects have been implemented, and a Georgia auxilian has served as president of the national organization.

Once again, we bring to the readers of the *Journal* a glimpse of some of the work being carried on at the national, state, and local levels by the members of our group.

Mrs. John G. (Glenda) Bates, of Cuthbert, offers a message as head of the AMA Auxiliary. Mrs. George R. (Judy) Jones, of the DeKalb Auxiliary, gives her views on state activities during her year as president with the theme "We Care." A look at what is involved in being a state president-elect is presented by Mrs. Robley D. (Ann) Smith, of Tifton.

The section spotlighting the counties covers a number of ongoing projects which have proven to be popular with our volunteers as well as with the public. These include the Learning Center being placed in the schools of Georgia which has progressed to Phase III; child abuse programs; the puppet show on drug abuse; screening for vision and hearing problems; support groups for parents of sick children; CPR refresher courses; the car seat program for child safety; hospice for the terminally ill; and breast self-examination for cancer.

Among the new projects discussed are Operation Care; colo-rectal screening; the SHAP program for stroke and heart attack prevention; good health and good music for school children; and the organization of a MADD chapter in Macon.

But along with the admirable work which we accomplish, some nagging questions remain to be answered. Are we really good "doctors' spouses"? Have we stopped to remember our main reasons for being members of medical auxiliaries? When we think of our *Objects* as listed in our handbooks, do we listen to the words: "The objects of the Auxiliary shall be to extend, through its members, the aims of the medical profession to all organizations which look to the advancement of health and health education . . ."?

Do we hear and follow the *Collect* as we recite at the opening of each meeting: "Keep us, O God, from pettiness, let us be large in thought, word and deed. Let us be done with fault-finding and leave off self-seeking . . ."?

In recent months, several incidents have occurred among our membership which have brought concern to our more thoughtful leaders and require that we place more emphasis upon our conduct as individuals in order to reach the goals which we have set for ourselves and our organization. Let us consider just a few of them.

Is a good ''doctor's spouse'' one who seeks personal acceptance by criticizing another doctor or his wife (or her husband) before the public in a beauty parlor, at a country club luncheon, at a garden club meeting, in the grocery store, or at one's job? Does the doctor's spouse have the best interests of the profession in mind when she/he tells a lay audience that ''doctors don't know anything about drugs,'' or that ''doctors don't study nutrition or prevention in medical schools''? Have we made our members (especially the younger ones) aware of what physicians really are required to cover in their curricula? Have we helped them to learn how to correct these misconceptions in a calm and intelligent manner? Do they have any idea at all about the history of medicine and the proper way to aid in projecting a positive image of the profession?

Our state auxiliary's first vice president, Mrs. Charles B. (Pearline Yeatts) Thomas, of Athens, has addressed some of the above issues in her editorial on ''Personal Growth.'' Mrs. Thomas holds a Ph.D. degree in psychology and teaches the subject at the University of Georgia. Admonishing us to acknowledge that we ourselves create the environment which has enhanced opportunities for criticism of the medical profession, she offers a means of change in the personal growth seminars which the state auxiliary began this year. Her advice should be heeded as we evaluate our topics for future seminars and seek to improve ourselves and the duties we perform.

Special thanks for this *Journal* forum in which to discuss the work of the Auxiliary go to the editors who have shown much patience and fortitude, and to Mrs. Thomas W. (Mary Ann) Marks, who assisted by gathering the material which we have used.

Mrs. Brit B. (Evelyn Ward) Gay, Jr.
Guest editor, Decatur

The Auxiliary: Its Past, Present, and Future

"COLLECTIVELY, we are a strong force that may be of some use in a quiet way to the medical profession. We, who know the unselfishness of those men of ours, can do much to enlighten a frequently misinformed public about the true character of medical work and its plans for public health and welfare. We can, in a non-aggressive way, offset much of the wicked propaganda constantly kept before an ignorant and deluded populace."



Glenda W. Bates

No, those aren't my words. They were written in 1934 by the then AMA Auxiliary President, Mrs. Robert Tomlinson. I use them to illustrate a point. We have come a long way both as individuals and as an organization. We have moved from doing things for those "unselfish men of ours" in a quiet way to become a strong force that is of vital importance to the medical profession. We must now move with certainty into an unknown future. For, with the rest of the world, we have one sure element in our lives, and that element is change.

Columnist Sidney Harris once observed that "We're funny about change — we love it and hate it at the same time. What we'd really like," he said, "is for things to stay the same and get better."

That's probably true for all of us, but it isn't possible. For change is not a sudden break with the past; it is a transition, a continuum with no beginning and no end. It is a steady momentum toward the future . . . from the no longer to the not yet . . . from the way things were to the way they will be . . . from where we are now to the where we want to be. And if we are to make the transition to the future, we can neither resist change nor fear it.

To do this we must work together — each of us as individuals and all of us as a collective force, using our diversity as well as our unity to make us strong. We must be involved in reaching the goals we have set as an organization to fulfill our hopes and dreams for the future.

Let's look first at membership, our most important commodity as a volunteer organization. And let's dream the dream that by 1988 — just 5 years from now — we are a volunteer force of 100,000 members. That's the goal that was set by the AMA Auxiliary Long-Range Planning Committee, which set in place a Fair Share plan for every member to join in. Each state has been given a pro-rata share of members to recruit in each of the 5 years ahead based on the present number of AMA Auxiliary members.

We need to sell present and potential members on the value of belonging — on the benefits of being able to share experiences with peers and of being able to work toward health goals. We need to sell them on the benefits of AMA Auxiliary membership.

For concerned members are needed to help us reach our goal of good health for the people of this nation. And we must join together, pull together as one viable force if we are to make an impact. In 1983-84, we set two major goals for health at the request of the AMA — prevention of child abuse and drunk driving. Just think what we can accomplish to help the one million children who are abused each year or the 27,000 people who are killed by drunk drivers if we put our force behind these projects.

We also need knowledgeable, committed members to influence legislation affecting health and medical care. Increasingly, legislatures at local, state, and federal levels are passing bills that affect the way our spouses practice. So we must be involved and aware. Our House of Delegates passed a resolution in June, 1983, to encourage physicians and their spouses to support the American Medical Political Action Committee. Let's encourage our members and their families to be involved in the 1984 presidential campaign.

These are trying times with regard to the issues facing medicine. These issues are crucial to the future of medical care, and the Auxiliary has the means to become a powerful public relations force for the medical profession. We come into contact daily with many people who know only what they hear on television or read in newspapers. If we become knowledgeable about such issues as competition, deregulation, and cost containment, we can correct much of the misinformation that affects people's views of the medical profession.

The AMA Auxiliary for the first time in its history has attempted to tell our story through a film, "The AMA Auxiliary — Your Voice Makes a Difference," which highlights the impact physicians' spouses can make in their communities through the AMA Auxiliary, as well as the impact they can make on the organization and its policies.

We, the Auxiliary, thank the physicians of the state of Georgia for the inspiration and assistance they have provided. They have enabled us to grow to our present strength. We believe that together — physicians and spouses united in common goals — we can fashion a future that is of *our* design.

In these times of change, we regard the AMA Auxiliary and the Auxiliary to the Medical Association of Georgia in the light of past accomplishments, with pride in our work today, and with hope for how this organization can better serve the medical profession, the people in our communities, and the physicians' spouses of this nation.

Mrs. John G. (Glenda) Bates
1983-84 President, AMAA
Randolph-Stewart-Terrell
Auxiliary

Personal Growth — A National Concern for Physicians and Their Spouses



Pearline Yeatts Thomas

During the past decade, physicians and medical auxilians have assumed the responsibility of forming an agenda for action that will address the personal identity crisis in the medical family community. We have only to evaluate the abuses, (drugs, child and spouse, emotional) as well as the divorce rate, to see that there is a crisis in the medical family.

In identifying the problem and seeking to find solutions, auxilians have discovered that the problem, and the blame for the problem, belongs to all of us. Therefore, we are cognizant that the solution to the problem also involves all of us.

In auxiliaries throughout the state and nation, we have seen the credentials of our prospective members become increasingly comprehensive. Yet during the same period, their desire to become involved in the medical community has declined. As the number of specialties in the medical profession has increased, the self-worth and self-abuse problems have also increased. This often leads to one group feeling degraded or intimidated by another group, thus ending the long-standing personal support group once found in the medical community.

Spouses and children are a part of the general values the physician places on himself and his colleagues; and they soon become representatives and catalysts for the same problems. Chief among the problems is the fact that the medical community has created an environment which has enhanced opportunities for other groups to downgrade medicine as one of society's esteemed professions. This downgrading then reinforces the original problem (one we created ourselves by downgrading each other) and expands the cycle for future attack.

In the past, talented, intelligent women felt that to be a mother and spouse was respected, and they found fulfillment and challenge in those roles. Today, increased career mobility for women, coupled with information suggesting that being a spouse and mother is not a secure or valuable role, diverts many potentially excellent physician support persons (spouses) into more "prestigious" careers.

Sadly, this very effort to find ways to enhance our self-esteem often leads us to engage in activities which remove us from support persons. This, in fact, often leads to the further degradation of the medical community in general, and to very destructive behaviors toward specific individuals.

Medical families can and should be examples of what a support group is. They can exemplify how spouses serve as a team in the analysis of any situation, in the decisions as to what needs to be done, how it is to be done, and who is best equipped to do the particular task. This is true in all facets of life — social, personal, financial, political, and otherwise. Families, like other groups, must be goal and task oriented. Each person must give moral support, and have an individual commitment, in order to nurture and protect quality and excellence within the group.

Recognizing the above, and hoping to assist in again having a strong united medical community, the Executive Board of the Auxiliary to the MAG elected to assist in providing personal growth opportunities for all spouses and/or physicians throughout the state. Each year, local and area seminars are being planned to assist every person in some area of personal concern.

The needs requested by the members in 1983-84 resulted in a personal growth

seminar being held in four areas of the state. These seminars, held at locations within 1½ hours drive from anyone wishing to attend, and led by an expert in each field, included sessions in the following:

1. Home computers — when do you use a home computer and how do you use it?
2. Investments and Financial Planning — how do you know what good investments are and how much do you invest where?
3. Antiques and Accessories — how to use what you have to the best advantage. How to add to what you have and what makes what better.
4. Parenting and Child Management — actual techniques and principles to use in child management to prevent drug abuse, stress, and parent burnout.

The seminars were evaluated as being the "best thing the auxiliary has ever done." Only two negative comments were made — both stating that not enough of these are done.

Areas of interest and need are being evaluated to determine the topics of the personal growth seminars for 1984-85. Any suggestions should be sent to local auxiliary presidents-elect or to the state auxiliary membership chairman.

We hope to have 100% of physicians' spouses involved in one of the 1984-85 Personal Growth Seminars.

Together we are all that we can be — apart we are only some of what we can be.

Mrs. Charles B. Thomas (Dr. Pearline Yeatts)
1st Vice President, AMAG
Crawford W. Long Auxiliary
Professor of Psychology, University of Georgia

The Right Stuff



Ann Smith

As President-elect of the Auxiliary to the Medical Association of Georgia, I have enjoyed a special vantage point from which to view Auxiliary members at work. I have observed that the Auxiliary is truly a ''power house'' — anxious to serve and sharing in health projects and programs that need our talents and expertise. Auxilians share a unique closeness. We enjoy our togetherness and learn much from each other.

Our ''Operation Care'' projects in several areas of the state are good examples of how much the membership rallies to get a job done. We were there when the physicians needed us to fill the role of volunteers. Consequently, ''Operation Care'' has been a successful endeavor.

We have continued with our ''Learning Center,'' emphasizing nutrition in Phase II, with the plans to develop aids for better mental health in Phase III. Here again, dedication and hard work have paid off.

Volunteerism is more important today than ever before. Budget cuts for health related programs on the state and national level would have left areas of community health unattended had it not been for volunteers. In many counties, auxilians have taken over eye and hearing screening and scoliosis screenings in local schools. We have many programs that assist the newborn and the elderly.

The local medical auxiliary can be the best public relations tool the physician has going for him. Auxilians can fill areas of service in the community that the busy physicians have no time for, and they can see to it that the media emphasizes the good that the medical community does.

Auxilians have worked faithfully in the area of legislation. Our letter-writing campaigns and telephone calls to our legislators get the lawmakers' attention. Our key contact program has given us quick and direct access to our legislators.

I have watched us grow this year, improve and learn, and we do that by taking advantage of workshops on the national level. Eleven Georgia auxilians attended the October, 1983, Leadership Confluence in Chicago. Eight county presidents-elect, the state membership chairman, the state president and state president-elect were enrolled in all the sessions. We had seminars on many subjects including: AMPAC, legislation, long and short-range planning, communicating orally, parliamentary procedure, organizational financial planning, effective parenting, drunk driving, drug abuse prevention, immunization, and others. We were involved in rap sessions and had excellent speakers for all luncheon and dinner meetings.

We never stop growing, we are always open to new ideas, and we want to seize every opportunity to serve our fellow man. Our world is constantly changing and our auxiliary must also change if we are to keep in step with the times and reach all potential members in our state as well as retain our present membership. We must attract the doctor's spouse who works and allow her to do volunteer work on her schedule. We must encourage male spouses to join our ranks and tap their unique talents. We are a hard working group, but we still have much to do. We have the ''Right Stuff'' to meet every challenge and grasp every opportunity as we work together for the benefit of better health for all Georgians.

Mrs. Robley D. (Ann) Smith
President-elect, AMAG
Tift Auxiliary

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If you're a surgeon or OB/GYN or other medical specialist, the Air Force may have a special practice for you.

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Auxiliary President's Letter

We Care

WHAT IS THE AUXILIARY to the Medical Association of Georgia? It is a statewide organization of 2600 physicians' spouses dedicated to helping and caring for those around us. It consists of a dozen members-at-large and 47 county auxiliaries that range in size from five to several hundred members. It is a unique organization whose only requirement is that one must be the spouse of a physician. That uniqueness binds us together with a special camaraderie.

The Auxiliary is continuing to meet a special challenge in today's society. What is that challenge? To meet the increasing need for volunteer services with fewer available volunteers. With more spouses pursuing their own careers, going back to school, and involved in other volunteer organizations, time has become a treasured commodity. We are attempting in these changing times to be flexible, to meet the needs and time constraints of our diversified members.

In meeting any change or challenge, I believe that attitude is the single most important factor. It is my belief that if we have a caring and positive attitude, then our challenges, changes, and goals can be met. We are associated with a profession that is based on healing and caring for the sick. On that basis, the theme for our auxiliary year was chosen — WE CARE. Think about it with me . . .

W — Working Together
E — Everyone Involved

C — Combined Efforts
A — Always Helping
R — Reaching Out
E — Endless Concern

As I have traveled across the state visiting with the county auxiliaries, listening to them, and watching them carrying out their many projects, I have observed their concern and care for those they serve.

Join me in this issue as you see the "auxiliary in action" at the county, state, and national levels. If you are a member, take pride in our organization. If you are not a member, join us today and share in that pride tomorrow.

Mrs. George R. (Judy) Jones
President
Auxiliary to the MAG

It is estimated that in DeKalb County, about 800 people are helped through this program every month.

SHAP — A Project for Prevention

MRS. ARTHUR L. (MARY) TRACHT, *Decatur**



DeKalb County Auxiliary members work with the county's Health Department to promote their Stroke and Heart Attack Prevention Program.

The Auxiliary to the DeKalb County Medical Society has been proud this year to support the Stroke and Heart Attack Prevention (SHAP) Program provided by the DeKalb County Health Department. The purpose of this program is to try to reduce disease and death from stroke and heart disease by identifying those most at risk and encouraging lifestyle changes through blood pressure screenings, education, follow-up, nutritional counseling, and referrals for medical treatment if necessary.

The program is mobile in that it is contained entirely in a van that travels all over the county, visiting health centers, shopping malls, work sites, and recreational facilities. The head of the program declares that the van will appear literally anywhere the volunteers are given permission to bring their program. Slowly, businesses are becoming more aware of the importance of monitoring the health of their employees, educating them about blood pressure, and giving nutritional counseling.

When the SHAP workers are allowed to come to a new site, they first do a blood pressure screening. If an extremely elevated blood pressure is found, that person is referred to one of several sources for immediate care: private physician, health department, or satellite health care station. Next will follow group and individual instruction on the facts about high blood pressure and how to avoid it. A large part of this instruction involves nutritional counseling. Such information as what foods to avoid and what foods to eat are taught. Basic facts about food groups are shared. If time permits, food preparation is discussed, and demonstrations are given. The program utilizes a slide show, "The Culinary Heart Kitchen." The DeKalb Auxiliary also plans to put into use its own low cholesterol cookbook, *A Way of Life*, prepared a few years ago as a service project.

The biggest burden thus far has been the follow-up part of the SHAP program. Once a contact has been made, follow-up to each site is made on a continuing basis. One can see that as the program becomes bigger, the needs increase drastically. It is estimated that in DeKalb County about 800 people are helped through this program every month.

* Mrs. Tracht is president of the Auxiliary to the DeKalb County Medical Society.

The rate of return and the results discovered warrant continuing this project for the benefit of the community.

Screening for Cancer

MRS. RAY (HILDA) TENENBAUM, *Dalton**

RESPONDING TO THE THEME "We Care," the membership of the Whitfield-Murray Medical Auxiliary has sought to reinforce existing projects and initiate new ones. One of these new endeavors was to participate in the Health Fair sponsored each year by the Hamilton Medical Center. The idea of Hemoccult testing was borrowed from the Crawford W. Long Auxiliary in Athens and presented to the members of the auxiliary and the local medical society for approval. A representative from Smith-Kline came to Dalton and told the prospective volunteers how to set up such a program. Funding came from business donations and the local medical society in the amount of $1,000. Mrs. Glen (Tracy) Boyd was in charge of securing funding, Mrs. Paul (Ann) Bradley kept the records, and Mrs. Emory (Susan) McKinney was in charge of organizing and implementing the program called "Colorectal Screening for Cancer."

A 7-minute orientation film obtained from Smith-Kline was shown to the auxiliary membership at the regular September meeting. This film, to be shown on request during the fair, explained the use of the kit. The film and kits also would be handed out to several Senior Citizens groups.

Auxiliary members signed up for 2-hour shifts in teams of four to dispense the kits at the fair, along with instructions on how to use them. The number of people projected to screen was taken from the number of those who had participated in the previous health fair — 1000 people.

Kits were ordered at cost by Hamilton Medical Center, and the results were read free of charge. Publicity was handled through the local newspapers, with several time-spaced articles explaining the importance of Hemoccult testing and that the tests would be available to the public without charge during the health fair from September 30 through October 1, 1983.



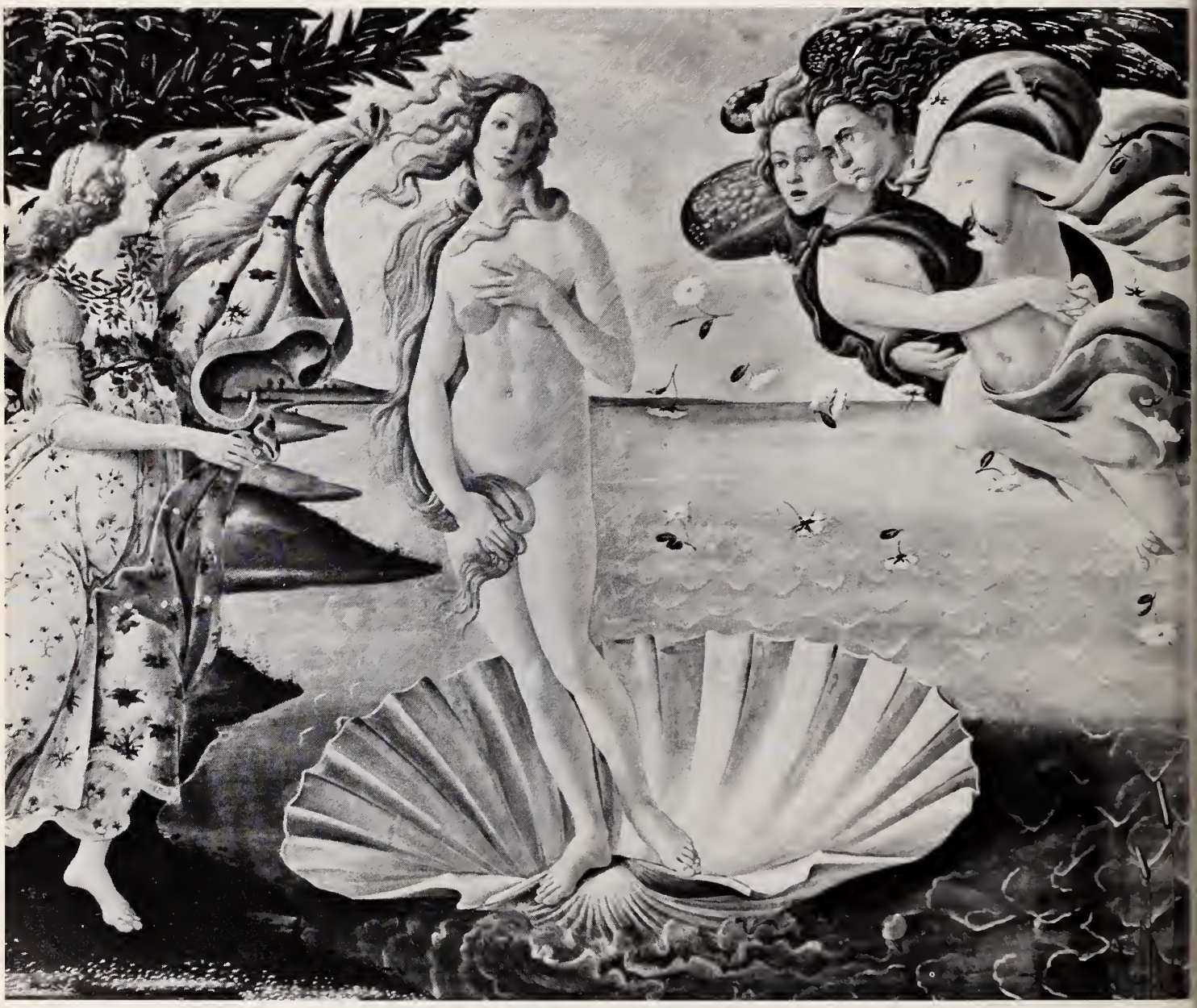
Mrs. Paul (Ann) Bradley, left, and Mrs. Emory (Susan) McKinney, right, worked on the Colorectal Screening project with Margaret Herring, center.

For follow-up purposes, an information card was completed for each person who picked up a kit. Three weeks after the fair, all of those who had not returned their kits were called and reminded to do so. Test results were telephoned to individuals as the tests were read. This telephoning was done by auxiliary members.

Fifty to sixty percent of the total membership of the Whitfield-Murray Auxiliary worked on this project. Approximately 600 kits were dispensed and about 300 were returned. To date, there have been 15 positive readings. The Whitfield-Murray Auxiliary feels that this rate of return and the results discovered warrant continuing the project for the benefit of the community.

* Mrs. Tenenbaum is president of the Whitfield-Murray Auxiliary.

Mammography can detect breast cancers even smaller than the hand can feel.



For too many years breast cancers that could have been cured could not be found. The only means available was the human hand. When mammography (low-dose x-ray examination) proved it could detect lumps infinitely smaller than fingers could feel, at minimal risk, a great breakthrough was achieved. Now there is hope that the leading cause of cancer deaths in women will lose its place in our lives.

Women, without symptoms of breast cancer, ages 35 to 39, should have one mammogram for the record; women 40 to 49 should have a mammogram every one to two years, and women 50 and over, once a year. All women are advised that monthly breast self-examination is an important health habit. Ask your local Cancer Society for free information on mammography and breast self-examination.

The American Cancer Society wants you to know.

AMERICAN CANCER SOCIETY®

Their projects are diverse and seek to meet the varied needs of those in their communities.

Spotlighting County Activities

MRS. THOMAS W. (MARY ANN) MARKS, *Atlanta**

Bibb County

HOSPICE OF CENTRAL GEORGIA has been adopted this year as a primary health project of the Bibb County Auxiliary. Members are working with the nursing coordinator and physicians in the community to provide support and assistance when families of terminally ill patients need to keep them in the home.

Other projects have included a Health Fair for the Bibb County Sheriff's Department and a joint project with the American Red Cross to instruct students in the Bibb County schools on "Health and Safety for Primary Grades." This latter course contains resource materials that provide learning experiences which will enhance the understanding, attitudes, and conduct of students in regard to individual and community health.

In addition to the usual wrapping paper sale to raise funds for AMA-ERF, auxiliary members played a tennis round robin with their husbands and sponsored a benefit dinner with the Wits End Players from Atlanta to add to the fund. Auxiliary members will also honor physicians on Doctors' Day by giving volunteer service to the Cripple Children's Clinic and purchasing equipment for the clinic. Special activities are in the planning stages for a spring affair for widows and retired physicians.

Clayton-Fayette

During the presidency of Naomi Liebman (Mrs. Paul H.), the Clayton-Fayette Auxiliary has implemented the groundwork for establishing a car seat loaner program at Clayton General Hospital. One hundred seats have been purchased, and money is available for 100 more seats. Under the direction of



Left to right: Mrs. Paul H. (Naomi) Liebman, president of the Clayton-Fayette Auxiliary; Mrs. Shirley Williams, president of the Clayton Hospital Auxiliary; and Mrs. Glenn S. (Michelle) Shear, safety chairman for the medical auxiliary, discuss plans for their car seat program.

Michelle (Mrs. Glen) Shear, seats will be provided at a reduced rate for rental to patients delivering at Clayton General Hospital. This project is being put into operation to coincide with the new Georgia law requiring all children under the age of 3 years to be secured in an approved crash-tested safety seat which is to be enforced after July 1, 1984.

Cobb County

An article on the William R. Dancy, M.D., Student Loan Fund in last February's *Journal of the MAG* stressed the need for more revenue. Accordingly, Cobb County formed a county Dancy Committee to not only increase funding but also to educate the membership regarding the history and purposes of the loan fund. Information about the program was distributed to Cobb Auxilians and a

* Mrs. Marks, a past president of the Atlanta auxiliary, is second vice president of AMAG and a former editor of *Pulse Line*.

September wrapping paper sale, chaired by Gwen Malcom (Mrs. George E., Jr.) brought in $510. Cobb County is proud to have increased its awareness and support of the Dancy Fund to assist Georgia medical students with expenses of their education.

DeKalb County

DeKalb is involved in many projects, including a county vision and hearing screening program to provide glasses and hearing aids to the health department, a FOCUS program supporting parents of critically and chronically ill children and a hotline for emergencies, a CPR refresher course for members and others in the community, and a car restraint project in conjunction with DeKalb General Hospital.

Floyd-Polk-Chattooga

The Floyd-Polk-Chattooga Auxiliary has emphasized people and their talents this year. Mrs. Lambros C. (Anne) Rigas, Floyd County Commissioner and chairman of the five-member commission, has been tapped as a national resource person by the AMA Auxiliary. She was the first woman and Republican elected to this post in 1980. She has been active in both state and local transportation, human services, church, and civic committees. She presently also serves her auxiliary as legislative chairman.

Other members of the auxiliary have volunteered their time in all areas of community service. They join with the Rome Junior Service League in a combined project to stem drug abuse among the youth of the tri-county area. Several video tapes were purchased to use as teaching tools in the public schools and private sectors warning the students of the dangers of drugs, including marijuana and alcohol.

The Floyd-Polk-Chattooga Auxiliary was the first auxiliary to purchase the entire "Learning Center" last year and has completed the teaching tools with the aids on nutrition. These tools have been distributed to more than 24,000 students and teachers in the area.

Other projects undertaken by this active auxiliary are: continued assistance to the Floyd County Health Department by furnishing auxiliary members to teach sexual awareness and pregnancy prevention classes at the Family Planning Clinic; a program to teach babysitters the basics of their job (GEMS); "Quality of Life" collection of books in a lending library on the subjects of children leaving home, coping with your role as a physician's wife, death, etc.; and a rewarding service called "Nursery," which provides sitters for young children and transportation to and from auxiliary meetings for members.

According to Mrs. Robert (Lynda Gerdin) Webb, treasurer of the auxiliary, one of the most heartwarming activities of their auxiliary is their Support Committee by which effort is made to strengthen the friendship and fellowship between members by such acts as delivering hot meals to new fathers, serving food to those members' families who have some pressing need, and by simply writing letters of encouragement and hope to let an auxiliary member know that there are people who sincerely care. With this warm atmosphere, the auxiliary has drawn in the resident wives as members and helped them with their adjustments to the new city and their role in the community.

Georgia Medical (Savannah)

A variety of projects make up Georgia Medical's year of service to the community. A Doctors' Day Road Race brought funds for the American Heart Association. A tennis tournament gave proceeds to the Safe Shelter of Savannah, a home for battered wives and their children. Members joined the Junior League in providing publicity and encouragement for the formation of town meetings to view the film, "The Chemical People."

The Savannah auxiliary is continuing its very successful GEMS program (Good Emergency Mother Substitutes) for training baby sitters. Feed-back from the schools, students, and parents has been very positive. Mrs. Donald Starr and Mrs. David Thomas will act as co-chairmen for the Spring 1984 course.

With the encouragement of the medical auxiliary, three area hospitals are adding car seat safety information to their pre-natal and post-partum educational programs. The American Red Cross is offering facilities as storage space and check-out area for the car seats. Co-chairmen of this project are Mrs. Sidney Bolch and Mrs. Edward Biggerstaff.

Phases I and II of the state auxiliary's Health Education Program are popular with members of the Georgia Medical Auxiliary. With Mrs. Dent Purcell, of Savannah, as state chairman, the local members have been busy raising funds with an auction and a raffle for a week-end at Hilton Head to bring in additional funds. During the past year, health education materials were placed in the Science Museum and the local schools. The Museum works with the schools, both public and private, to provide classes and exhibits to all area students.

The Savannah group also awards two nursing scholarships to students enrolled at Armstrong State College's school of nursing.

Auxiliary to the Medical Association of Atlanta

Among its many other community projects, the Atlanta auxiliary has given much time to helping the medical society restore its popular home, the Academy of Medicine on West Peachtree Street. In



Mrs. Thomas W. (Mary Ann) Marks and Dr. Dan Byrd view the painting he gave to the Auxiliary room of the Academy of Medicine. Entitled "The Battle of Camperdown — October 11, 1757," it was painted by an English artist, George Chambers, 1803-40.

addition to contributing almost $100,000 in funds to assist the restoration of the building, the auxiliary has seen its Auxiliary Lounge, first dedicated to the wives of physicians in 1941 when the building was completed, rededicated to them with a plaque on the door reading: "This room is dedicated to the Auxiliary to the Medical Association of Atlanta, Inc., whose vision inspired the restoration of this building and whose cooperation has been invaluable."

The furnishings in the room include an antique Waterford chandelier, now 217 years old, which was presented previously to the wives of physicians, "present and future," of the Fulton County Medical Society (now the Medical Association of Atlanta, Inc.). A painting over a sideboard in the room was given by the family of the late Dr. Grant Wilmer in his memory. Another, given by Dr. Dan Byrd, is called "The Battle of Camperdown — October 11, 1757." It was painted by an English artist, George Chambers, 1803-1840.

The building has been in constant use by various organizations since its restoration and recently has received two distinguished awards. In May of 1983, the Atlanta Urban Design Commission at its 6th annual awards of excellence in urban design competition gave the Academy of Medicine one of its 12 awards for the year. In December, 1983, the Georgia Association of the American Institute of Architects, at its annual meeting in Macon, gave one of 3 awards to Surber, Barber and Mooney, architects for the restoration.

Julie (Mrs. Emmerich) von Haam, current president of the Atlanta auxiliary, is bringing back some of the old-time activities, such as card parties and fashion shows which once filled the calendars of members, to raise funds for projects. A recent such party, chaired by Judy (Mrs. Louis) Martin, brought in enough money to honor retired physicians at a Doctors' Day luncheon.

Newton-Rockdale

A membership drive opened the current year for the Newton-Rockdale Auxiliary with the idea of bringing both current and prospective new members up to date on the many accomplishments of the past year and the many planned for the future.

The Learning Center had high priority and components of Phase II were purchased for both counties' schools. A Key Contact Program was organized with the auxiliary's president, Mrs. Rodney (Evelyn) Utke, and Mrs. Ethel Boyle, who is also a member of the Rockdale County School Board, serving on a committee along with the medical society in the area of legislation.

In order to participate more fully in the community's affairs, the auxiliary took part in the Conyers Olde Towne Festival with a fund-raising booth for community projects. The auxiliary made hand and thumb print pictures for children, using donated materials collected by the ways and means chairman, Mrs. Marty Ross. The auxiliary also joined member Jimi Bowen's local chapter of the Kappa Delta Sorority in an Organ Donor Program with the distribution of information leaflets and a program with a speaker from the Atlanta Regional Organ Procurement Agency.

Finally, the Newton-Rockdale Auxiliary is assisting in promoting their historic community's growth by making new members aware of the area's past. Historian Carolyn Brown, who is also president-elect of the Conyers Historical Society, has assisted by giving a report on early medicine in Newton and Rockdale Counties, and bringing older members of the communities as her special guests.

Richmond County

The focus of the Auxiliary to the Richmond County Medical Society this year has been in the area of cancer — breast self examination and what the individual woman can do to insure early detection and cure. The goal is to deliver this message to the public through small group encounters. Auxiliary volunteers are being trained by American Cancer Society personnel.

The program consists of a brief introduction stating the startling statistics that one in 11 women will have breast cancer and that only 22% of the women in the United States perform this examination on a regular basis. A short film, provided by the cancer society, is shown, demonstrating the techniques of self-examination. Participants are encouraged to practice with a life-like model under the supervision of the auxiliary volunteers. A question and answer period follows.



Mrs. Barry Cook (Patty) (L), Medical College of Georgia Nursing instructor, demonstrates breast self-examination on model of "Betsi" to Mrs. J. William McCord (Nancy), president of the Richmond County Auxiliary.

The auxiliary's community health chairman and a representative of the American Cancer Society will appear on television as a means of reaching such groups as garden clubs, church groups, and other women's organizations. In the future, the auxiliary plans to take this project into the health classes of the schools. Brochures, *How to Examine Your Breast,* have been placed in the lingerie departments of area stores.

The Richmond County Auxiliary also is continuing its participation in the county's emerging chapter of MADD, Operation Care, and the puppet show, "Drugs are a Drag," in the elementary schools.

Whitfield-Murray

Ann Viamonte planned a linen shower for the Impaired Physicians program to bring in many new and used items. A fun-time auction for Family and Children Services and the Learning Center, Phase II, was enjoyed by members and raised $950. Red ribbons instead of carnations were given to doctors on Doctors' Day, and more infant car seats were added to its loaner program in honor of physicians. Existing programs on child abuse were augmented, and plans were discussed for beginning a MADD chapter in the near future.

* * *

Many of the county auxiliaries, including Georgia Medical, Richmond, Peach Belt, and Tift have purchased copies of the state auxiliary's new history, *The Medical Profession in Georgia, 1733-1983,* to be presented to libraries in their towns in honor of physicians on Doctors' Day. Other counties are expected to order copies of this book for similar purposes.

References:

1. Stone PH, Turi ZG, Muller JE: Efficacy of nifedipine therapy for refractory angina pectoris. *Am Heart J* 104:672-681, September 1982.
2. Antman E, Muller J, Goldberg S, et al: Nifedipine therapy for coronary-artery spasm: Experience in 127 patients. *N Engl J Med* 302:1269-1273, June 5, 1980.

BRIEF SUMMARY
PROCARDIA® (nifedipine) **CAPSULES** For Oral Use

INDICATIONS AND USAGE: I. Vasospastic Angina: PROCARDIA (nifedipine) is indicated for the management of vasospastic angina confirmed by any of the following criteria: 1) classical pattern of angina at rest accompanied by ST segment elevation, 2) angina or coronary artery spasm provoked by ergonovine, or 3) angiographically demonstrated coronary artery spasm. In those patients who have had angiography, the presence of significant fixed obstructive disease is not incompatible with the diagnosis of vasospastic angina, provided that the above criteria are satisfied. PROCARDIA may also be used where the clinical presentation suggests a possible vasospastic component but where vasospasm has not been confirmed, e.g., where pain has a variable threshold on exertion or in unstable angina where electrocardiographic findings are compatible with intermittent vasospasm, or when angina is refractory to nitrates and or adequate doses of beta blockers.

II. Chronic Stable Angina (Classical Effort-Associated Angina): PROCARDIA is indicated for the management of chronic stable angina (effort-associated angina) without evidence of vasospasm in patients who remain symptomatic despite adequate doses of beta blockers and or organic nitrates or who cannot tolerate those agents.

In chronic stable angina (effort-associated angina) PROCARDIA has been effective in controlled trials of up to eight weeks duration in reducing angina frequency and increasing exercise tolerance, but confirmation of sustained effectiveness and evaluation of long-term safety in those patients are incomplete.

Controlled studies in small numbers of patients suggest concomitant use of PROCARDIA and beta blocking agents may be beneficial in patients with chronic stable angina, but available information is not sufficient to predict with confidence the effects of concurrent treatment, especially in patients with compromised left ventricular function or cardiac conduction abnormalities. When introducing such concomitant therapy, care must be taken to monitor blood pressure closely since severe hypotension can occur from the combined effects of the drugs. (See Warnings.)

CONTRAINDICATIONS: Known hypersensitivity reaction to PROCARDIA.

WARNINGS: Excessive Hypotension: Although in most patients, the hypotensive effect of PROCARDIA is modest and well tolerated, occasional patients have had excessive and poorly tolerated hypotension. These responses have usually occurred during initial titration or at the time of subsequent upward dosage adjustment, and may be more likely in patients on concomitant beta blockers.

Severe hypotension and or increased fluid volume requirements have been reported in patients receiving PROCARDIA together with a beta blocking agent who underwent coronary artery bypass surgery using high dose fentanyl anesthesia. The interaction with high dose fentanyl appears to be due to the combination of PROCARDIA and a beta blocker, but the possibility that it may occur with PROCARDIA alone, with low doses of fentanyl, in other surgical procedures, or with other narcotic analgesics cannot be ruled out. In PROCARDIA treated patients where surgery using high dose fentanyl anesthesia is contemplated, the physician should be aware of these potential problems and, if the patient's condition permits, sufficient time (at least 36 hours) should be allowed for PROCARDIA to be washed out of the body prior to surgery.

Increased Angina: Occasional patients have developed well documented increased frequency, duration or severity of angina on starting PROCARDIA or at the time of dosage increases. The mechanism of this response is not established but could result from decreased coronary perfusion associated with decreased diastolic pressure with increased heart rate, or from increased demand resulting from increased heart rate alone.

Beta Blocker Withdrawal: Patients recently withdrawn from beta blockers may develop a withdrawal syndrome with increased angina, probably related to increased sensitivity to catecholamines. Initiation of PROCARDIA treatment will not prevent this occurrence and might be expected to exacerbate it by provoking reflex catecholamine release. There have been occasional reports of increased angina in a setting of beta blocker withdrawal and PROCARDIA initiation. It is important to taper beta blockers if possible, rather than stopping them abruptly before beginning PROCARDIA.

Congestive Heart Failure: Rarely, patients, usually receiving a beta blocker, have developed heart failure after beginning PROCARDIA. Patients with tight aortic stenosis may be at greater risk for such an event.

PRECAUTIONS: General: Hypotension: Because PROCARDIA decreases peripheral vascular resistance, careful monitoring of blood pressure during the initial administration and titration of PROCARDIA is suggested. Close observation is especially recommended for patients already taking medications that are known to lower blood pressure. (See Warnings.)

Peripheral edema: Mild to moderate peripheral edema, typically associated with arterial vasodilation and not due to left ventricular dysfunction, occurs in about one in ten patients treated with PROCARDIA. This edema occurs primarily in the lower extremities and usually responds to diuretic therapy. With patients whose angina is complicated by congestive heart failure, care should be taken to differentiate this peripheral edema from the effects of increasing left ventricular dysfunction.

Drug interactions: Beta-adrenergic blocking agents: (See Indications and Warnings.) Experience in over 1400 patients in a non-comparative clinical trial has shown that concomitant administration of PROCARDIA and beta-blocking agents is usually well tolerated, but there have been occasional literature reports suggesting that the combination may increase the likelihood of congestive heart failure, severe hypotension or exacerbation of angina.

Long-acting nitrates: PROCARDIA may be safely co-administered with nitrates, but there have been no controlled studies to evaluate the antianginal effectiveness of this combination.

Digitalis: Administration of PROCARDIA with digoxin increased digoxin levels in nine of twelve normal volunteers. The average increase was 45%. Another investigator found no increase in digoxin levels in thirteen patients with coronary artery disease. In an uncontrolled study of over two hundred patients with congestive heart failure during which digoxin blood levels were not measured, digitalis toxicity was not observed. Since there have been isolated reports of patients with elevated digoxin levels, it is recommended that digoxin levels be monitored when initiating, adjusting, and discontinuing PROCARDIA to avoid possible over- or under-digitalization.

Carcinogenesis, mutagenesis, impairment of fertility: When given to rats prior to mating, nifedipine caused reduced fertility at a dose approximately 30 times the maximum recommended human dose.

Pregnancy: Category C. Please see full prescribing information with reference to teratogenicity in rats, embryotoxicity in rats, mice and rabbits, and abnormalities in monkeys.

ADVERSE REACTIONS: The most common adverse events include dizziness or light-headedness, peripheral edema, nausea, weakness, headache and flushing each occurring in about 10% of patients, transient hypotension in about 5%, palpitation in about 2% and syncope in about 0.5%. Syncopal episodes did not recur with reduction in the dose of PROCARDIA or concomitant antianginal medication. Additionally, the following have been reported: muscle cramps, nervousness, dyspnea, nasal and chest congestion, diarrhea, constipation, inflammation, joint stiffness, shakiness, sleep disturbances, blurred vision, difficulties in balance, dermatitis, pruritus, urticaria, fever, sweating, chills, and sexual difficulties. Very rarely, introduction of PROCARDIA therapy was associated with an increase in anginal pain, possibly due to associated hypotension.

In addition, more serious adverse events were observed, not readily distinguishable from the natural history of the disease in these patients. It remains possible, however, that some or many of these events were drug related. Myocardial infarction occurred in about 4% of patients and congestive heart failure or pulmonary edema in about 2%. Ventricular arrhythmias or conduction disturbances each occurred in fewer than 0.5% of patients.

Laboratory Tests: Rare, mild to moderate, transient elevations of enzymes such as alkaline phosphatase, CPK, LDH, SGOT, and SGPT have been noted, and a single incident of significantly elevated transaminases and alkaline phosphatase was seen in a patient with a history of gall bladder disease after about eleven months of nifedipine therapy. The relationship to PROCARDIA therapy is uncertain. These laboratory abnormalities have rarely been associated with clinical symptoms. Cholestasis, possibly due to PROCARDIA therapy, has been reported twice in the extensive world literature.

HOW SUPPLIED: Each orange, soft gelatin PROCARDIA CAPSULE contains 10 mg of nifedipine. PROCARDIA CAPSULES are supplied in bottles of 100 (NDC 0069-2600-66), 300 (NDC 0069-2600-72), and unit dose (10x10) (NDC 0069-2600-41). The capsules should be protected from light and moisture and stored at controlled room temperature 59° to 77°F (15° to 25°C) in the manufacturer's original container.

More detailed professional information available on request

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"I can do things that I couldn't do for 3 yrs. including joining the human race again."



Quotes from an unsolicited letter received by Pfizer from an angina patient. While this patient's experience is representative of many unsolicited comments received, not all patients will respond to Procardia nor will they all respond to the same degree.

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"My daily routine consisted of sitting in my chair trying to stay alive."

"My doctor switched me to PROCARDIA[*] *as soon as it became available. The change in my condition is remarkable."*

"I shop, cook and can plant flowers again."

"I have been able to do volunteer work...and feel needed and useful once again."

PROCARDIA can mean the return to a more normal life for your patients—having fewer anginal attacks,[1] taking fewer nitroglycerin tablets,[2] doing more, and being more productive once again.

Side effects are usually mild (most frequently reported are dizziness or lightheadedness, peripheral edema, nausea, weakness, headache and flushing, each occurring in about 10% of patients, transient hypotension in about 5%, palpitation in about 2% and syncope in about 0.5%).



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(NIFEDIPINE) *Capsules 10 mg*

*Procardia is indicated for the management of:
1) Confirmed vasospastic angina.
2) Angina where the clinical presentation suggests a possible vasospastic component.
3) Chronic stable angina without evidence of vasospasm in patients who remain symptomatic despite adequate doses of beta blockers and/or nitrates or who cannot tolerate these agents. In chronic stable angina (effort-associated angina) PROCARDIA has been effective in controlled trials of up to eight weeks' duration in reducing angina frequency and increasing exercise tolerance, but confirmation of sustained effectiveness and evaluation of long-term safety in these patients are incomplete.

Please see PROCARDIA *brief summary on adjoining page*

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J-4044 January 1984

Some of the ongoing purposes of MADD are to increase the public's awareness of the problem and to support appropriate legislative reforms.

MADD Chapter Is Formed in Macon

MRS. BRIT B. (EVELYN WARD) GAY, JR., ***Decatur****

Mrs. Robert (Nony) McMichael, a member of the Bibb County Medical Auxiliary and a past president of the Auxiliary to the MAG, was instrumental in beginning a chapter of Mothers Against Drunk Drivers (MADD) in her city, and with the help of volunteers from several other groups has begun to extend the program into other areas of the state.

It was at the urging of Assistant District Attorney Vernon Beinke, a neighbor across the street in Macon, that Mrs. McMichael got involved in the effort to curb drunk driving in Georgia in the summer of 1982. In December of that year, she attended a meeting of the Governor's Task Force on Alcoholism and Driving. Mr. Beinke advised that an assistant to Mrs. McMichael should be selected from outside the auxiliary so as to set up an "umbrella type organization," to be composed of a variety of groups. She chose Nancy Prescott from the League of Women Voters.

Papers for a Macon chapter were sent to MADD national headquarters, and a questionnaire came which had to be filled out before the group could begin functioning. Mrs. McMichael was told that only 1 in 10 people finished the course required for participation, and if a person worked she should forget it. A minimum of 15 hours each week would be required for work on the project.

After approval was received, research was necessary to answer questions required. This effort took 13 weeks. One night while engaged in this research for a charter, Mrs. McMichael and Nancy Prescott were allowed to sit in the police van while officers made routine license checks on people going into a well-known bar in Macon. They were there from 10 p.m. until 2 a.m. and saw 12 arrests made, all en route *to* the lounge. On the following Monday morning, they saw several of these people come into court "a great deal more rumpled and subdued than they were on Saturday night."



In their DUI Task Force van, Macon officers P. J. O'Hanlon (left) and D. G. Oxley explain the intoximeter to Mrs. Nony McMichael.

Later, they were asked by leaders of the national group if the questions they had asked during interviews with Bibb legislators could be used as a model for future nationwide research.

Mrs. McMichael says that the news media aided the project to get underway. *The Macon Telegraph* carried a feature story about the organization, and phone calls concerning membership increased. To receive a charter, it was necessary for a chapter to build its membership to 20 paid members. When research was completed, an organizational meeting was held on May 25, 1983, at the Washington Memorial Library, and 23 members were counted — 12 of them from families of victims of drunk drivers.

Two television stations covered the meeting, and more favorable stories appeared in the papers. As a result, Mrs. McMichael was invited to attend a meeting of the Macon mayor's Task Force on DUI. At the second meeting of the new Macon organization in June, 1983, which was held at the

* Mrs. Gay is Chairman of the Research and Romance of Medicine Committee of the Auxiliary of the MAG. She is a member of the Auxiliary to the Medical Association of Atlanta

Y.W.C.A., the program's speaker was a member of the mayor's task force (a vice president for a beer distributor) who spoke on his frustration at being unable to reach students in the local schools about too much drinking at senior parties.

A regular meeting place was chosen at the June meeting. Future meetings would be held at the Macon Chamber of Commerce on the 4th Monday each month at 7:30 p.m.

In September, 1983, the Auxiliary to the Bibb County Medical Society adopted the MADD program as their safety project. Mrs. McMichael and Mrs. Jack (Connie) Menendez would be co-chairmen. Other auxiliary members working with them were Mrs. Stephen (Beverly) Noller, Mrs. Andrew (Marjorie) Lawrence, Mrs. Charles (Shirley) Lanford, president of the auxiliary, and Mrs. Larry (Carole) Grant.

One of the most effective events to publicize the project was the candle-lighting vigil held during the time when every chapter in the nation (about 300) observed the week of December 11-18 as National Drunk and Drugged Driving Awareness Week. Macon's mayor issued a proclamation to Mrs. McMichael on television, and the Macon vigil, commemorating 38 middle Georgia victims of drunken drivers, was held on December 11 on Coleman Hill overlooking the lights of the city, followed by a reception at the Mercer law building at the top of the hill. On the last day of the week, auxiliary members manned a booth at Westgate Mall to show a video tape called "You're Under Arrest," and to distribute literature about MADD.

On February 21, 1984, an all day meeting was held at the Mercer Medical School. The title of the program was "Drug Use or Abuse." Participating were Dr. William Dudney, of Warner Robins, Mrs. McMichael, and Assistant District Attorney Beinke. The program was planned by auxilian, Mrs. Andrew (Marjorie) Lawrence.

The Macon chapter of MADD now has 45 members. The group continues to work with other organizations such as the Pilot Club and the League of Women Voters. The Insurance Women of America offered secretarial help and a local printer has volunteered his services.

Mrs. McMichael says that she is proud of the participation she has received from other groups and the obvious support of the entire city of Macon, from the news media to the district attorney, assistant district attorney, the director of curriculum for the school system, the sheriff's task force, and Representative Denmark Groover, who is responsible for the "legally drunk" point determination being set at .12 instead of the .10 which was formerly used.

Mrs. McMichael points out that the ongoing purposes of the group are many: to present awareness programs so as to bring the attention of the public to the problem at target times — Mother's Day, graduation parties, all seasonal holidays, etc.; educational programs in the schools, at PTA meetings, or any place the group's representatives are invited to show films, present speakers, or discuss possible legislation; legislative action which includes circulation of petitions to raise the legal drinking age to 21, and backing of the law to permit the owner of a bar to be held liable for damage if a person who receives too many drinks there is involved in an automobile accident.

The group also offers help to families of victims of drunk drivers by giving comfort, support, and direction to finding whatever assistance is needed. Eventually this will include financial help, legal aid, and rehabilitation.

Members of the group have attended court cases, two of which were felony trials. They prepared detailed reports to present at the next meeting of MADD and made follow-ups on convictions. They found that one felon was already out of jail, and the other was requesting that his sentence be reduced. The MADD volunteers keep files on all cases, and pay "drop-in visits" to city court to see that sentences are handed out evenly.

The group's leaders have made several appearances on television, prepared radio spots, and participated in interviews and on panels with Macon's chief of police. Mrs. McMichael was the subject of "Profile" on local television, and has spoken at the Academy for the Blind, at Plant Scherer of the Georgia Power Company for three sessions with 90 people in each, at Chapel Hill Academy, the Pilot Club, at the World Congress Center in Atlanta for the American College of Emergency Room Physicians, in Dublin to help set up a MADD chapter there, at Tatnall Square Academy, and the Junior Woman's Club. Future engagements are planned for Windsor Academy, for an auxiliary seminar, Suburban Women's Club, Sandersville Rotary Club, Wellness Fair at the Coliseum in Macon for the Cherry Blossom Festival, in Forsyth at the Hubbard Elementary School, and for a program of the Pilot Club to include surrounding counties. During May, members of the Macon chapter of MADD will assist the SADD (Students Against Drunk Driving) at all high schools and private academies by showing to upper grades the film "Death in the Fast Lane."

Several members of the national staff of MADD came to Atlanta recently to help set up a state coordinating committee for the program. Mrs. McMichael was named chairman. And the Macon newspaper, in its section called "Salutes," complimented Mrs. McMichael recently for her leadership in establishing the MADD chapter in their city.

The perseverance exhibited by the Auxiliary in this project to bring it to a successful point is indicative of their dedication and willingness to contribute.

Doctor-of-the-Day Medical Aid Station in the Capitol Gets a New Look

MRS. WILLIAM C. (BARBARA) TIPPINS, JR., ***Decatur****

If Earle Stanley Gardner were writing, the title might be "The Case of the Disappearing Room." If a decorating editor were writing, the title very possibly might be, "How to Decorate a Room on Half a Shoestring."

It all began on a gray day in December near the end of 1982 when Mrs. David Thibodeaux (Barbara), President of the Auxiliary to the Medical Association of Georgia, was approached by a representative of MAG about the possibility of the Auxiliary's accepting as a project the decorating of the Medical Aid Station in the Capitol. This facility, which has medical services for legislators and workers rendered by members of the Medical Association of Georgia each day while the General Assembly is in session, was being moved from the fourth floor to a new location on the second floor.

Mrs. Thibodeaux, knowing the Auxiliary never turned down a challenge, said she felt her group would be happy to do this. Then the real challenge was uncovered — the room was still being renovated, there were no funds, and the General Assembly would convene on January 10, 1983.

The chairman of the legislative committee, Mrs. William C. Tippins, Jr. (Barbara), was called, and the project began. First there were trips to the Capitol for room measurements, floor plan outlines, and ascertainment of the most necessary priorities. It was decided that placing pictures over the long wall of existing cabinets and on the other wall space was the place to begin.



Mrs. William C. (Barbara) Tippins, Jr., of the DeKalb Auxiliary and Representative John Linder of DeKalb County.

Visits to flea markets, craft shows, boutiques, and art galleries confirmed the notion that nothing they contained was free. After exhausting several enticing leads for freebies, the committee faced the cold fact that time was playing against the Auxiliary's efforts.

Barbara Thibodeaux, being the innovative, resourceful person that she is, found $200 could be produced from her existing budget and allocated for this project.

On a routine trip to the Capitol, Barbara Thibodeaux and Mrs. George Jones (Judy) discovered the Medical Station had been stripped down to its plumbing, gone were the walls, gone was the ceiling, as were the cabinets — more renovations were being made.

(Continued on page 190)

* Mrs. Tippins, a member and past president of the DeKalb Auxiliary, is third vice president of AMAG and a former co-editor of *Pulse Line*.

"Slim Goodbody" was presented in concert in a show entitled "A Celebration of Your Self."

Good Health and Good Music

MRS. THOMAS A. (SHERRY) WADE, JR., ***Columbus****

THIS YEAR, in addition to all of its other projects, the Muscogee County Medical Auxiliary planned a very exciting event for the entire community. "Slim Goodbody" was presented in concert with the Columbus Symphony Orchestra. The show, entitled "A Celebration of Your Self," is centered around nutrition and maintenance of good health. This important message is set to the music of Grieg, Britten, Beethoven, Copland, Mozart, and Brahms, as well as to several songs which the performer had composed especially for the show.

While putting on his act, John Burstein (as Slim Goodbody) wears a body stocking on which the body's internal organs are painted. He has presented this show with the cooperation of symphony orchestras in all sections of the country and in Hawaii and Canada. According to *Newsweek*, "He has performed for thousands to unanimous rave reviews." The Detroit Symphony Orchestra billed him with the words, "He shows kids that good music, serious music can be entertaining. Slim Goodbody is effective because of his excellence."

On Sunday, February 19, Burstein appeared in Columbus at the annual Kinder Concert which is open to the public. There was a $2.00 ticket charge to help cover the orchestra's expenses. On Monday, February 20, two shows were presented at no charge to 3,800 Muscogee County school children in the fourth through sixth grades. These students are the participants in our county's Health Improvement Program (H.I.P.), and they had studied a unit in their curriculum featuring Slim Goodbody prior to attending the concert. Both the H.I.P. director and the cultural arts coordinator for the school system helped prepare the students for the combined health and cultural message which they received.

The idea for this program originated when the president of the Auxiliary to the Muscogee County Medical Society was attending the confluence in Chicago in 1982, and a coalition among organizations for community benefit was being stressed. When the Columbus auxiliary learned that Slim Goodbody's fee would be too much for their organization to finance alone, the president approached the Junior League of Columbus, which has an ongoing interest in education in the county, and the Columbus Symphony Women's Association about co-sponsoring his appearance. As a result, each organization committed $1,500 to the project. Everyone involved was excited about Slim Goodbody's presentation and the fact that this health education message could potentially reach 5,700 people.

The Auxiliary to the Muscogee County Medical Society feels that this has been an excellent reinforcement for material covered in the county's H.I.P. Program.

* Mrs. Wade is president of the Auxiliary to the Muscogee County Medical Society.

The MAG is indebted to the auxilians who screened calls to insure that those most in need were provided the physicians' services.

Because We Care — Operation Care

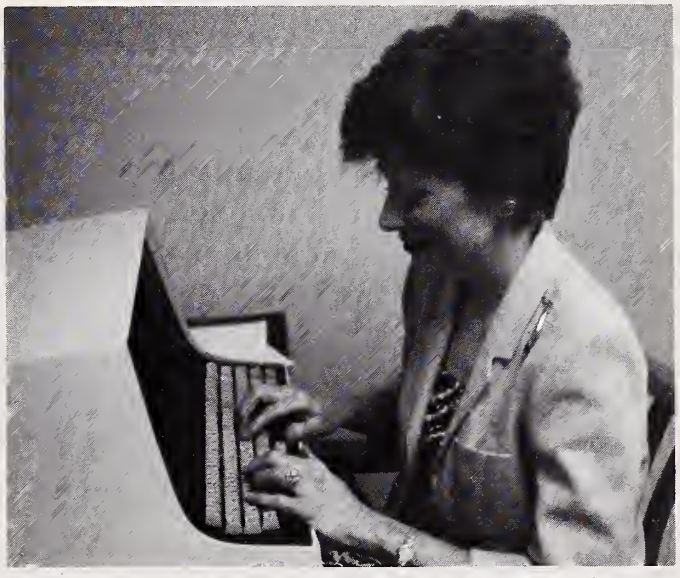
MRS. CHARLES W. (GRACE) WALDEN, *Decatur**

On the morning of May 2, 1983, several volunteers from the DeKalb County Medical Auxiliary began answering the special telephone lines at the Medical Association of Georgia's offices to take calls from unemployed people in the metropolitan Atlanta area who were in search of medical care. Over the next 8 months, thousands of calls were to come in, and these calls were answered by volunteers from the Cobb, DeKalb, Newton-Rockdale, and Medical Association of Atlanta Auxiliaries, as well as by some volunteer nurses and the MAG staff.

While physicians over the years have traditionally treated patients without regard to their ability to pay, the MAG felt that many people who were temporarily unemployed as a result of the recent recession and who had no health insurance but needed medical care were not seeking help. Therefore, the MAG established a temporary program — Operation Care — which would cease as soon as the economy picked up and MAG felt there was no longer a need for a special program.

The volunteers from the above-mentioned auxiliaries manned the special telephones from 9 a.m. to 1 p.m. each day, Monday through Friday. Through spot announcements on the local radio and TV stations, interested persons learned the telephone number and the hours to call. In addition to publicity on the local radio and television and in the metropolitan Atlanta newspapers, the Operation Care program was featured on national network news programs, in *Medical World News,* and in *The New York Times.*

Not all of the callers phoning the Operation Care office qualified for the program. Those callers who did not qualify were referred to either county health departments or other health agencies. Prior to the onset of Operation Care, all member-physicians of MAG were asked if they would be willing to participate in the program, in addition to the patients whom they already were treating without charge. About 650 physicians responded in the affirmative. The patients who were referred to these physicians were instructed that *only* physicians' fees would be covered under the program. Any hospital or laboratory fees incurred would be the responsibility of the patient and the hospital or laboratory involved.



Mrs. John P. (Margaret) Syribeys, of DeKalb County, routes calls during Operation Care.

During the 8 months the project was in operation, approximately 1500 referrals were made to the participating physicians.

Operation Care projects soon spread to other parts of the state where they were set up by medical societies and their auxiliaries. Among the counties participating were Richmond, Clark, Muscogee, Chatham and Dougherty. The members of the county medical auxiliaries taking part in this project not only got better acquainted as a result of their team work, but they also realized a fulfillment that can come only from helping people in genuine need.

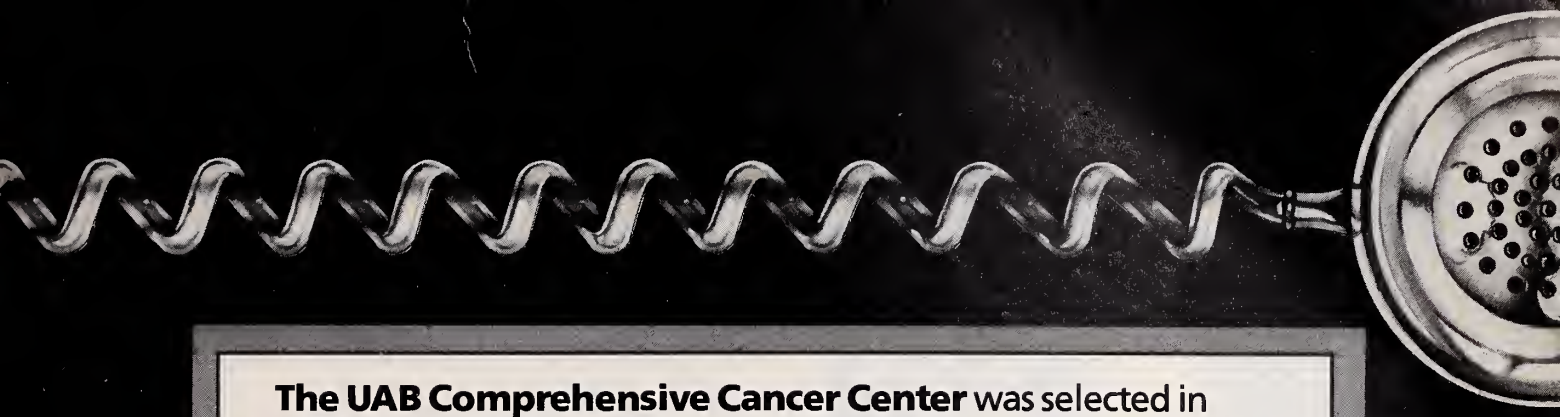
* Mrs. Walden is a past president of the DeKalb County Auxiliary and a former editor of *Pulse Line.*

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- **The use of the implantable drug infusion pump for continuous chemotherapy.**
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- **Laser Bronchoscopy.**
- **Combined modality treatment for lung cancer.**

The Cancer Center carries out clinical research in the diagnosis and therapy of various anemias, immune cytopenias and coagulation disorders. In addition to chemotherapy, the Center is studying the use of hyperthermia, monoclonal antibodies and the pharmacology of anticancer drugs.

The Comprehensive Cancer Center is one of 60 departments, divisions and centers of the University of Alabama Medical Center accessible to you through this toll-free service.

The Center welcomes physician inquiries. To speak with a physician, to consult about a patient or to refer a patient, telephone by using the toll-free MIST number. This service, including the telephone call, is free.

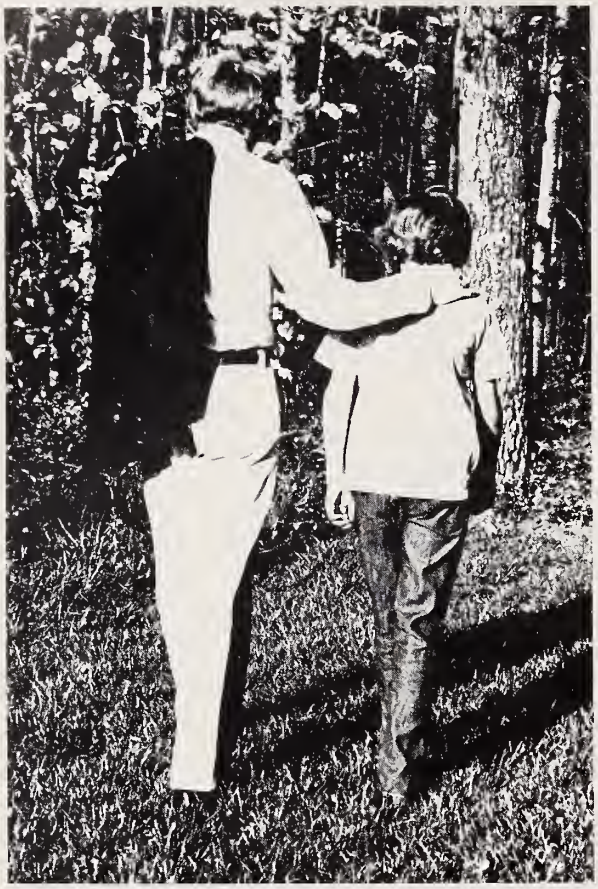
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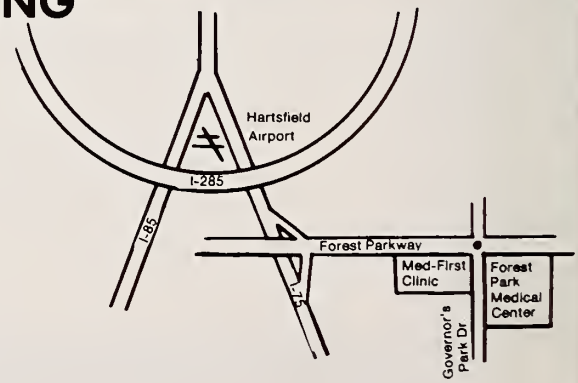
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JOURNAL
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The 130th Annual Session of the Medical Association of Georgia

On April 26, 1984, the Medical Association of Georgia's (MAG's) House of Delegates will convene at 8:00 p.m. in the Ballroom of the Ritz Carlton Buckhead Hotel in Atlanta. The House of Delegates will be preceded by a General Session of MAG members at 7:00 p.m.

This Annual Session will confine itself to the business affairs of the Association. By House of Delegates action in 1973, the scientific portion of the meeting was separated from the business portion and is held in November of each year.

Hotel Reservations

The Ritz Carlton Buckhead Hotel is the headquarters for this meeting. All MAG delegates, alternate delegates, and officers have received hotel reservation cards from MAG Headquarters. All others must make reservations directly with the hotel. The address is: Ritz Carlton Buckhead Hotel, 3434 Peachtree Road, N.E., Atlanta, GA 30326. Phone: 404/266-2622 or 1/800/241-3333.

Registration

Registration facilities will be maintained in the Ritz Carlton Buckhead Hotel for the delegates, alternate delegates, directors, and all members. Registration hours will be as follows:

Thursday, April 26 ... 3:00 p.m.-7:00 p.m.
Friday, April 27 .... 7:30 a.m.-12:00 noon
Saturday, April 28 .... 8:30 a.m.-5:00 p.m.
Sunday, April 29 ..... 7:00-12:00 noon

Message Center

The Auxiliary to the MAG will maintain a message desk in the Ritz Carlton Buckhead Hotel for the convenience of the membership. The messages will be posted on a bulletin board at the message desk.

Dr. Boyle to Address the House

Joseph F. Boyle, M.D., President-Elect of the American Medical Association, will address the MAG House of Delegates on Saturday morning, April 28. Dr. Boyle will speak on current issues facing us.

General Session

The opening General Session will be called to order by MAG's president, William W. Moore, Jr., M.D., on Thursday, April 26, at 7:00 p.m. in the Ballroom. Featured at this opening ceremony will be the report of the President of the Auxiliary to MAG.

There will be no General Session on Saturday.

The Second General Session will be held following adjournment of the House of Delegates. Newly elected officers will be installed during the Saturday House.

House of Delegates

The first session of the House of Delegates will convene on Thursday, April 26, at 8:00 p.m. in the Ballroom. Nominations for MAG officers will be made, and reports of officers and committees will be presented. Resolutions and other new business will be placed before the House. Reference Committees will be appointed, and all resolutions and reports will be referred by the Speaker to the appropriate Reference Committees.

The second session of the House of Delegates will convene at 9:00 a.m. on Saturday, April 28, in the Ballroom. Reference Committees will report to the House at this time.

Reference Committees

According to the Bylaws of the Association, all resolutions and reports which contain recommenda-

tions must be referred to Reference Committees for open hearings. All members are invited and encouraged to appear before the Reference Committees to express their views. The Committees will open their hearings on Friday, April 27, at 9:00 a.m.

Election of Officers

Nominations for the officers of the Association will be made during the first session of the House of Delegates on Thursday, April 26.

The election will take place during the House on Saturday morning, April 28. The Tellers will pass out, collect, and count the ballots, and the results will be announced when the House reconvenes after the lunch break. All newly elected officers will be installed during the meeting on Saturday.

President's Reception

The MAG will honor its president at a reception to be held at 7:00 p.m., Saturday, April 28. MAG President Dr. William W. Moore, Jr. will present all the awards at this time, and Dr. S. W. Clark, Jr., President-Elect, will address the group.

Alumni Events

Receptions and dinners sponsored by the various medical school alumni organizations are often held during the Annual Session. Notice will be made prior to the Annual Session.

GaMPAC Breakfast

GaMPAC will sponsor a breakfast on Friday morning, April 27 at 7:30 a.m. in the Ritz Carlton Buckhead Hotel.

Directors and Alternate Directors

District	Directors	Alternate Directors	Term Ending
1	Leon E. Curry, Metter	Richard I. Staiman, Statesboro	1985
2	Sammie Dixon, Tifton	Lannie Copeland, Moultrie	1985
3	Virgle McEver, Jr., Warner Robins	Wentford A. Spears, Warner Robins	1985
6	Samuel Brewton, Jr., Thomaston	Norman P. Gardner, Thomaston	1986
7	Bannester L. Harbin, Rome	John Atha, Rockmart	1986
8	Joe C. Stubbs, Valdosta	S. Wm. Clark, Jr., Waycross	1984
9	Rupert Bramblett, Cumming	Peter Lampros, Toccoa	1984
10	Wm. M. Headley, Milledgeville	Charles Wills, Washington	1985
Bibb County Medical Society			
	Beverly B. Sanders, Macon	Charles A. Lanford, Macon	1984
Cobb County Medical Society			
	Charles Underwood, Marietta	Dan B. Stephens, Marietta	1984
Crawford W. Long Medical Society			
	William C. Holmes, Athens	E. Van Herrin, Athens	1985
DeKalb Medical Society			
	H. Duane Blair, Decatur	Charles McDowell, Decatur	1984
Dougherty County Medical Society			
	Frank Middleton, III, Albany	Carl V. Hancock, Jr., Albany	1986
Floyd-Polk-Chattooga Medical Society			
	Robert A. Farrell, Rome	Joel Todino, Rome	1984
Hall County Medical Society			
	John Reed, Gainesville	James H. Leigh, Jr., Gainesville	1986
Medical Association of Atlanta			
	William C. Collins, Atlanta	Bob G. Lanier, Atlanta	1986
	T. J. Anderson, Jr., Atlanta	W. Ben Spearman, Atlanta	1984
	J. Harold Harrison, Atlanta	William C. Waters, III, Atlanta	1986
Georgia Medical Society			
	Joe L. Nettles, Savannah	Clyde L. Olson, Savannah	1985
Muscogee County Medical Society			
	Jack A. Raines, Columbus	E. M. Molnar, Columbus	1986
Richmond County Medical Society			
	Luther Thomas, Augusta	James L. O'Quinn, Augusta	1984

Criteria for Selection of Recipients of MAG Awards

Hardman Cup

This award is presented for "the active achievement of anyone who in the judgement of the Association has solved any outstanding problem in public health or made any discovery in medicine or surgery" or such contribution to the science of medicine. The recipient of this award will be selected by a five-man secret committee. Nominations for this award are to be made by component county medical societies, and all nominations must be accompanied by supporting biographic data and received at MAG Headquarters no later than March 1. If no nominations and supporting data are received, no award will be made. No nominations for this award will be accepted from the floor. If given, this award will be presented on Saturday, April 28. By custom, this award usually has gone to a Georgia physician; however, this is not required by the terms of the letter from Governor Hardman establishing this award.

Distinguished Service

The Distinguished Service Award is presented for distinguished and meritorious service which reflects credit and honor on the Association. Nominations for this award should be made by component county medical societies and must be received at MAG Headquarters no later than March 1. They must be accompanied by biographic data supporting the nomination. The recipient will be selected by a five-man secret committee and presentation will be made on Saturday, April 28.

Civic Endeavor Award

This award, presented for the first time at the 1969 Annual Session, will be given pursuant to an action taken by the 1968 House of Delegates in Augusta. This award is to be given for outstanding public service and participation in civic activities. Component county medical societies are invited to make nominations for this award supported by appropriate data which must be received at MAG Headquarters no later than March 1. The recipient of this award will be selected by a three-man secret committee which will determine if the nominees meet the requirements of the resolution which created this award. Presentation will be made on Saturday, April 28.

Family Physician of the Year

This award is presented to an outstanding family physician in Georgia. Presentation of the award is made at the Annual Session. The president of the Georgia Academy of Family Physicians (or his designee in the event of his absence) will present this award on Saturday, April 28.

Officers of the Association 1983-1984
Board of Directors of the Medical Association of Georgia

Office		Term Ending
*PRESIDENT	William W. Moore, Jr., Atlanta	1984
*PRESIDENT-ELECT	S. William Clark, Jr., Waycross	1984
*IMMEDIATE PAST PRESIDENT	Charles D. Hollis, Jr., Albany	1984
PAST PRESIDENT	L. Newton Turk, III, Atlanta	1984
PAST PRESIDENT	H. Hilt Hammett, Jr., LaGrange	1984
*FIRST VICE PRESIDENT	Eloise B. Sherman, Savannah	1984
*SECOND VICE PRESIDENT	John D. Watson, Columbus	1984
*CHAIRMAN OF THE BOARD OF DIRECTORS	Joe L. Nettles, Savannah	1984
*SECRETARY	William D. Logan, Jr., Atlanta	1984
*TREASURER	James H. Sullivan, Columbus	1984
*SPEAKER OF THE HOUSE	Jack F. Menendez, Macon	1986
*VICE SPEAKER OF THE HOUSE	James A. Kaufmann, Atlanta	1986
VICE CHAIRMAN, BOARD OF DIRECTORS	William C. Collins, Atlanta	1984
EDITOR, *JMAG* (Ex-Officio member of Board)	Edgar Woody, Atlanta	1984

* Denotes Executive Committee

Component County Society Representation to the 1984 MAG House of Delegates

(1983 CMS Member Count for 1984 Delegates to Annual Session)

County Medical Society	Number of Delegates
Altamaha	1
Baldwin	3
Barrow	1
Bartow	1
Ben Hill-Irwin	1
Bibb	12
Blue Ridge	1
Burke	1
Camden-Charlton	1
Carroll-Haralson	2
Cherokee-Pickens	1
Clayton-Fayette	5
Cobb	12
Coffee	1
Colquitt	2
Coweta	2
Crawford W. Long	5
Decatur-Seminole	1
DeKalb	14
Dougherty	6
Douglas	1
Elbert	1
Emanuel	1
Flint	1
Floyd-Polk-Chattooga	5
Franklin	1
Georgia Medical Society	11
Glynn	4
Gordon	1
Gwinnett-Forsyth	3
Habersham	1
Hall	5
Hart	1
Jackson-Banks	1
Jefferson	1
Laurens	2
Lumpkin	1
McDuffie	1
Medical Association of Atlanta	55
Meriwether-Harris-Talbot	1
Mitchell	1
Muscogee	10
Newton-Rockdale	2
Oconee Valley	1
Ocmulgee	1
Ogeechee River	2
Peach Belt	3
Randolph-Stewart-Terrell	1
Richmond	18
Screven	1
South Georgia	4
Southeast Georgia	1
Southwest Georgia	1
Spalding	2
Stephens-Rabun	2
Sumter	2
St. John's Parish	1
Thomas Area	3
Tift	2
Troup	3
Upson	2
Walker-Catoosa-Dade	2
Walton	1
Ware	3
Washington	1
Wayne	1
Whitfield-Murray	3
Wilkes	1
Worth	1

MAG Delegates to AMA

Delegates	Term Ending
J. Dan Bateman, Albany	12/31/84
C. Emory Bohler, Brooklet	12/31/85
H. Hilt Hammett, Jr., LaGrange	12/31/84
William W. Moore, Jr., Atlanta	12/31/85
Harrison L. Rogers, Jr., Atlanta	12/31/84
Charles D. Hollis, Jr., Albany	12/31/83

Alternate Delegates	Term Ending
Carson B. Burgstiner, Savannah	12/31/85
S. William Clark, Jr., Waycross	12/31/84
Joe C. Stubbs, Valdosta	12/31/84
C. Peter Lampros, Toccoa	12/31/83
James H. Sullivan, Columbus	12/31/84
L. Newton Turk, III, Atlanta	12/31/83

Official Program

(All functions of the House of Delegates will be held in the Ritz Carlton Buckhead Hotel — Atlanta)

Thursday, April 26

4:00 p.m. to 7:00 p.m. **Registration of Delegates and Other Session Attendees**
Location: Ballroom Foyer

7:00 p.m. **General Session**
Location: Ballroom
Presiding: William W. Moore, Jr., M.D., President
Opening Ceremonies
Report of the President of the Auxiliary to the Medical Association of Georgia, Mrs. George R. Jones of Decatur
Announcements
Recess

8:00 p.m. to 10:00 p.m. **House of Delegates, First Session**
Location: Ballroom
Presiding, Jack F. Menendez, M.D., Speaker, and James A. Kaufmann, M.D., Vice Speaker
Presentation, Correction, and Adoption of the Minutes of the 1983 House of Delegates
Appointment of Convention Committees
Nominations for Association Officers and AMA Delegates
Reports of Officers and Committees
Introduction of New Business
Announcements
Recess

Friday, April 27

7:30 a.m. **Registration**
Location: Ballroom Foyer

9:00 a.m. **Reference Committee Hearings**

Saturday, April 28

8:00 a.m. **Registration**
Location: Ballroom Foyer

9:00 a.m. **House of Delegates, Second Session**
Location: Ballroom

7:00 p.m. **President's Reception**
Presentation of Association Awards
Family Physician of the Year
Hardman Cup
Civic Endeavor Award
Distinguished Service Award

Dr. Boyle To Address House

Joseph F. Boyle, M.D., a private practitioner of internal medicine and diseases of the chest from Los Angeles, California, and President-Elect of the American Medical Association, will address the 1984 MAG House of Delegates.



Joseph F. Boyle, M.D.

Doctor Boyle, elected to the AMA's Board of Trustees in 1975, served as its Chairman from June, 1981 to June, 1983. He has long been active in organized medicine at the local, state and national levels. He has served in numerous elected capacities including President of the California Medical Association and the Los Angeles County Medical Association, Speaker of the California Medical Association House of Delegates and Delegate to the AMA's House of Delegates.

Born in Jersey City, New Jersey, on November 21, 1924, Doctor Boyle received his M.D. degree from Temple University School of Medicine. His postgraduate work was done in both New Jersey and California. Doctor Boyle is a Diplomate of the American Board of Internal Medicine.

In addition to being on the staff of several Los Angeles area hospitals, Doctor Boyle has been Associate Clinical Professor of Medicine at the University of Southern California, School of Medicine, since 1954, and Past President of the California Chapter of the American College of Chest Physicians.

Doctor Boyle's community activities have included the Los Angeles Area Chamber of Commerce, and the California State Chamber of Commerce where he recently completed a three-year term on its Board of Directors, the State of California Disaster Office, and the California Citizens Committee on Tort Reform. In 1966 he served as President of the Board of Directors of the Tuberculosis and Health Association of Los Angeles County. He is currently a member, Board of Directors, National Organization on Disability.

Auxiliary to the Medical Association of Georgia

59th Annual Meeting

April 27-28, 1984
Ritz Carlton
Atlanta, Georgia

1983-84 Theme: We Care

Welcome to Atlanta

It is a pleasure to welcome all auxilians to the 59th annual convention of the Auxiliary to the MAG. This year's convention, hosted by the Auxiliary to the DeKalb Medical Society, will be held on Friday, April 27, and Saturday, April 28, at the new Ritz Carlton Hotel conveniently located across from Lenox Square and adjacent to Phipps Plaza on our famous Peachtree Road.

We look forward to sharing with you an informative and fun-filled convention along with the excitement of our city with its many fine restaurants, shopping facilities, activities, and historic sights.

Mrs. Kenneth (Carolyn) Hoose
Convention Chairman

President's Invitation

The Auxiliary to the Medical Association of Georgia invites you to the 1983-84 Convention at the fabulous Ritz-Carlton Hotel in Atlanta. Please join us for fun, friendship, caring, and for sharing our year's accomplishments.

Business, outstanding speakers, and social events have been planned. Our hope is that this will be an interesting, exciting, and enjoyable convention for

Mrs. George R. (Judy) Jones
President, A-MAG

Rules to Govern the Convention

1. The voting body of the convention shall consist of the members of the Executive Board of the Auxiliary to the Medical Association of Georgia and the duly accredited delegates from the county auxiliaries. No one is entitled to vote until registered.
2. To gain recognition, a delegate is requested to rise, address the chair, give her name and the name of her auxiliary.
3. No delegate shall speak more than twice on the same subject, and is limited to two minutes each time.
4. Badges must be worn by members of the voting body during all general meetings of the convention.
5. Delegates' privileges are not transferable.
6. All motions shall be presented in writing to the Recording Secretary. They shall be signed by persons making the motion.
7. All persons appearing on the program must be seated near the platform when the meeting opens.

Auxiliary Program

Thursday, April 26, 1984

3:00-5:00 **Registration and Information**

7:00 **MAG General Session**
(All MAG and Auxiliary members and guests invited)
Presiding: WILLIAM W. MOORE, JR., M.D., President
Opening Ceremonies
Report of the President of the Auxiliary to the MAG: MRS. GEORGE R. JONES
Address: MRS. JOHN G. BATES, President, Auxiliary to AMA
Greetings from Southern Medical Association Auxiliary: MRS. J. REARDON, McLean, Virginia

Friday, April 27

9:00-5:00 **Registration and Information**
Hospitality and Exhibits

10:00 **Pre-Convention Executive Board Meeting**
Presiding: MRS. GEORGE R. JONES
Business Meeting

12:00 **Auxiliary Luncheon & Fashion Show**
(All delegates, board members, Auxilians, and guests)
Presiding: MRS. GEORGE R. JONES

2:00 **Auxiliary General Meeting**
Presiding: MRS. GEORGE R. JONES
Call to Order
Spotlighting: County Presidents 1983-84
Pledge of Allegiance and Collect
President's Greetings: MRS. GEORGE R. JONES
Welcome: MRS. KENNETH HOOSE, Convention Chairman
Introduction of Head Table: MRS. GEORGE R. JONES
Introduction of Past Presidents
Introduction of Guests
Greetings from the MAG: WILLIAM W. MOORE, JR., M.D., President
Address: MRS. JOHN G. BATES, Georgia, President, Auxiliary to the AMA
Greetings from Auxiliary to Southern Medical Association: MRS. J. REARDON, President
Business Meeting
Introduction of Pages
Credentials Report
Convention Standing Rules: MRS. MILTON BRYANT
Parliamentarian
Adoption of Program: MRS. THOMAS MARKS, 2nd Vice President
Roll Call: MRS. DIETZ CARPENTER, Recording Secretary
Minutes: MRS. DIETZ CARPENTER, Recording Secretary
Officers' Reports
Committee Reports
New Business: Election 1983-84 Nominating Committee
Announcements
Recess

5:00-7:00 **Auxiliary to MAG President's Entertainment**

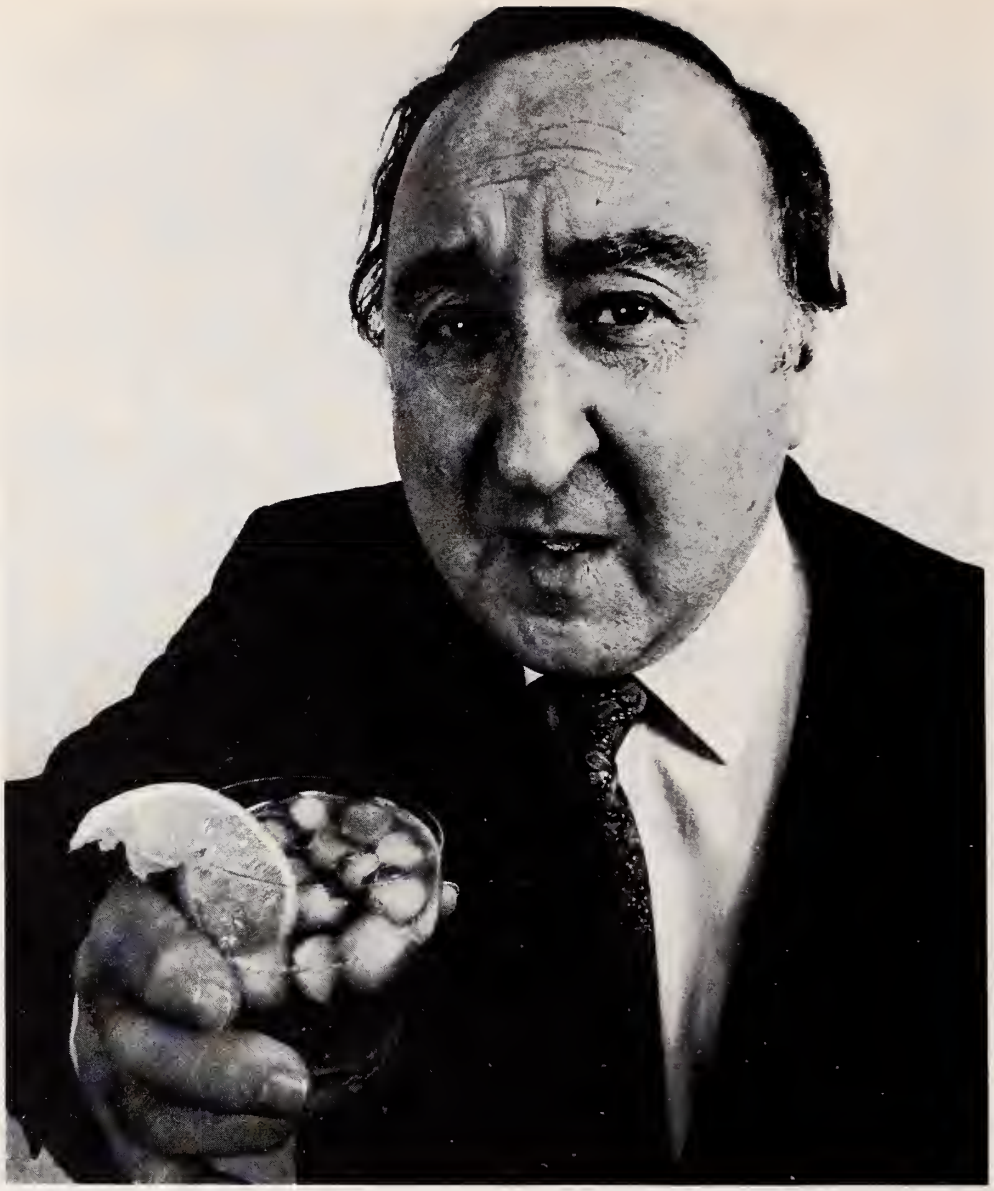
Saturday, April 28

8:30 to 12:30 **Registration and Information**
Hospitality and Exhibits

9:00 **Second General Meeting**
Presiding: MRS. GEORGE R. JONES
Call to Order
Introduction of Guests
Introduction of Past Presidents
Memorial Service: MRS. JAMES MANNING, Chairman
Greetings from JOSEPH BOYLE, M.D., President-Elect, AMA
New Business
A. Revised Report of Credentials Committee
B. Report of Awards Committee
1. **Achievement Award:** MRS. CARL S. PITTMAN, Chairman
2. **James M. Brawner, M.D. Certificate of Excellence Award:** MRS. DAVID C. THIBODEAUX, Chairman
3. **Safety:** MRS. ALVA L. MAYES, JR., Chairman
4. **Scrapbook:** MRS. JAMES H. SULLIVAN, Chairman
5. **AMA-ERF Award:** MRS. JOHN P. SYRIBEYS, Chairman
6. **Membership Award:** MRS. CHARLES THOMAS, Chairman
7. **Learning Center:** MRS. DENT PURCELL, Chairman
8. **Doctor's Day:** MRS. W. JACK SMITH, Chairman

Speaker: FRANCES PATTON STATHAM, Author of Several Best Sellers
D. Report of the 1983-84 Nominating Committee: MRS. DAVID C. THIBODEAUX, Chairman
E. Election of Officers
F. Installation of Officers
G. Presentation of 1984-85 President's Pin and Gavel
H. Inaugural Address and Announcements of 1984-85 Chairmanships
I. Presentation of Past President's Pin
J. Announcements

12:00 **Adjournment**
12:30 **Post Convention Board Meeting Luncheon**
Past President's Luncheon



He Thought That Drinking Wouldn't Make Any Difference, Even Though He Was on a New Medication. But It Did.

Now he knows that alcohol and some medicines don't mix. In fact, more than half the 100 most prescribed drugs have at least one ingredient that can cause trouble if taken while drinking alcohol. The result of mixing these drugs (alcohol is a drug) may be no more than simple temporary illness, but some combinations can be dangerous, even deadly.

So, don't make a test tube out of your body. Be sure to tell your doctor or druggist about any medications you are taking and be sure to ask about the consequences of mixing a newly prescribed drug with alcohol.

Also, make it a habit to check the label carefully when you get a drug, whether it's a prescription or over-the-counter medication.

And when you get any prescription, be sure you know—

- **The name** of the drug
- **Its purpose**—what conditions does it treat?
- **How and when** to take the drug—and when to stop taking it
- What **food, drinks and other drugs to avoid** while taking it
- What **side effects** may result—are they serious, short-term, long-term, etc.?

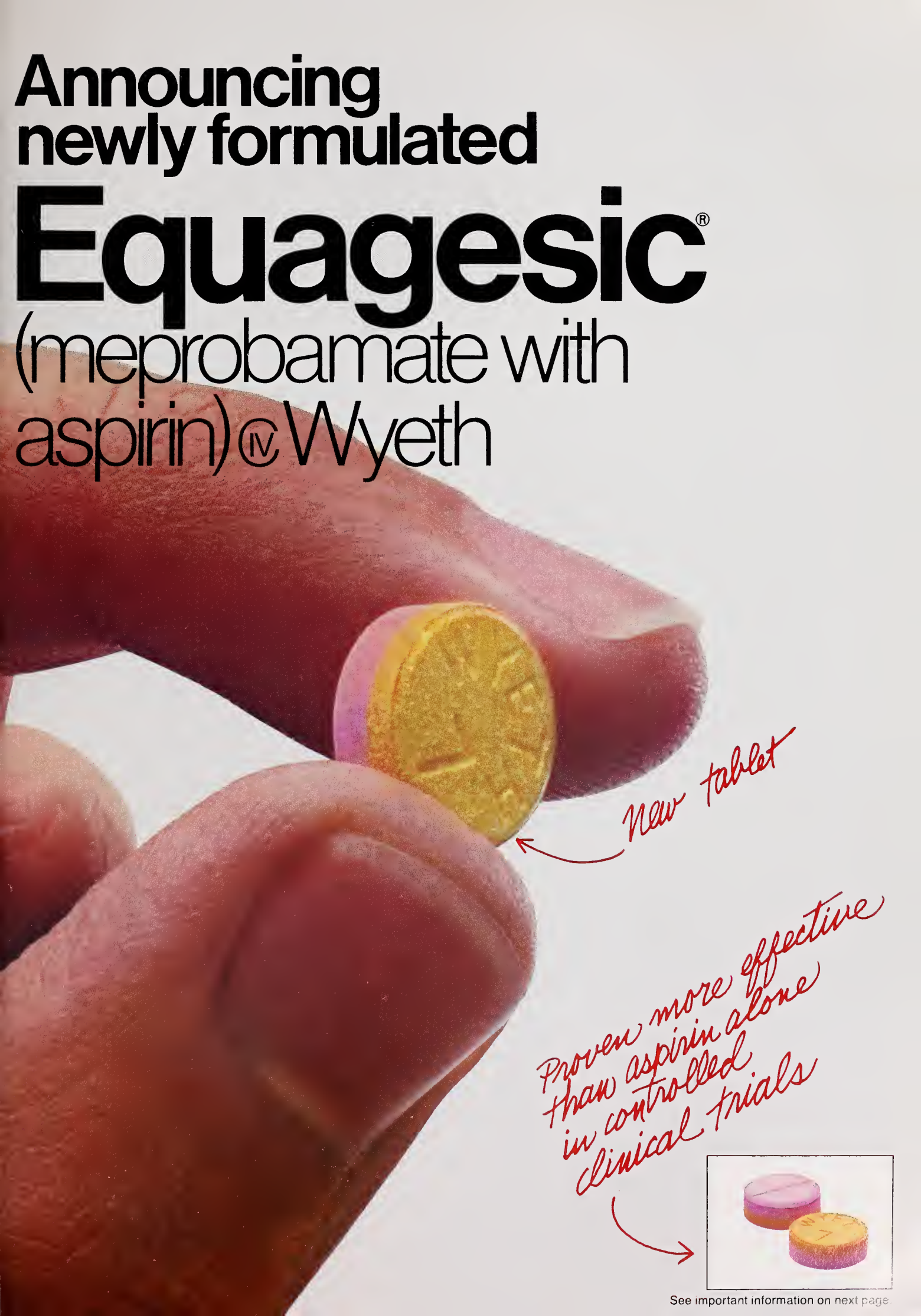
If you have any questions about your prescription, *ask your doctor or pharmacist.*

A message from the Food and Drug Administration. For more material about being an informed patient, write to: FDA, HFE-88, Rockville, Md. 20857.

Announcing newly formulated

Equagesic®

(meprobamate with aspirin) Wyeth



See important information on next page

Equagesic®
(meprobamate with aspirin) © Wyeth

Effective adjunct in short-term treatment of pain
accompanied by tension and/or anxiety in patients with musculoskeletal disorders.



when anxiety magnifies the perception of pain



1-2 tablet dosage 3 or 4 times daily

Equagesic®
(meprobamate with aspirin) © Wyeth

(BRIEF SUMMARY)

DESCRIPTION:
Each tablet contains 200 mg meprobamate and 325 mg aspirin.

INDICATIONS:
Adjunct in short-term treatment of pain accompanied by tension and/or anxiety in patients with musculoskeletal disease. Clinical trials demonstrated that in these situations relief of pain is somewhat greater than with aspirin alone. Effectiveness in long-term use, i.e. over 4 months, has not been assessed by systematic clinical studies. Physicians should periodically reassess usefulness of drug for individual patients.

CONTRAINDICATIONS:
ASPIRIN: Allergic or idiosyncratic reactions to aspirin or related compounds.

MEPROBAMATE: Acute intermittent porphyria; allergic or idiosyncratic reactions to meprobamate or related compounds, e.g. carisoprodol, mebutamate, or carbromal.

WARNINGS:
ASPIRIN: Use salicylates with extreme caution in patients with peptic ulcer, asthma, coagulation abnormalities, hypoprothrombinemia, vitamin K deficiency, or those on anticoagulants. In rare instances, aspirin in persons allergic to salicylates may result in life-threatening allergic episodes.

MEPROBAMATE: DRUG DEPENDENCE: Physical and psychological dependence, and abuse have occurred. Chronic intoxication from prolonged ingestion of, usually, greater than recommended doses is manifested by ataxia, slurred speech, and vertigo. Therefore, carefully supervise dose and amounts prescribed and avoid prolonged use, especially in alcoholics and others with known propensity for taking excessive quantities of drugs. Sudden withdrawal after prolonged and excessive use may precipitate recurrence of preexisting symptoms, e.g. anxiety, anorexia, or insomnia, or withdrawal reactions, e.g., vomiting, ataxia, tremors, muscle twitching, confusional states, hallucinosis, and, rarely, convulsive seizures. Such seizures are more likely in persons with CNS damage or preexistent or latent convulsive disorders. Onset of withdrawal symptoms occurs usually within 12 to 48 hours after discontinuation; symptoms usually ceasa within next 12- to 48-hour period. When excessive dosage has continued for weeks or months, reduce dosage gradually over 1 to 2 weeks rather than stop abruptly. Alternatively, a short-acting barbiturate may be substituted, then gradually withdrawn.

POTENTIALLY HAZARDOUS TASKS: Warn patients meprobamate may impair mental or physical abilities required for potentially hazardous tasks, e.g., driving or operating machinery.

ADDITIVE EFFECTS: Since CNS-suppressant effects of meprobamate and alcohol or meprobamate and other psychotropic drugs may be additive, exercise caution with patients taking more than one of these agents simultaneously.

USAGE IN PREGNANCY ANO LACTATION: An incraased risk of congenitel malformatlona aeeoclatad with minor trenquilizers (meprobamete, chlordiazepoxide, and dlezepam) during first trimester of pregnancy, hee been suggestad in severel studies. Baceuse use of thase drugs le rarely e mattar of urgency, thair use during this perlod shouid almoet elweya ba avoided. The possibility that e woman of childbaering potential may be pregnant at time of institution of tharepy should ba considarad. Advise patients if they become pragnant during therapy or intand to become pregnant to communicata with their physiciane about daalrebility of discontinuing tha drug.

Meprobemate passee tha placental barrier. It is present both in umbilical-cord blood at or neer maternel plasme levels and in breast milk of lacteting mothers at concentratione two to four times that of maternel plesma. Whan use of meprobamata is contempleted in breestfeeding patients, consider tha drug's higher concentretions in breast milk es compered to meternel plasme levels.

USAGE IN CHILDREN: Keep preparations with aspirin out of reach of children. Equagesic® (meprobamate with aspirin) is not recommended for patients 12 years of age and under.

PRECAUTIONS:
ASPIRIN: Salicylates antagonize uricosuric activity of probenecid and sulfinpyrazone. Salicylates are reported to enhance hypoglycemic effect of sulfonylurea antidiabetics.

MEPROBAMATE: Use lowest effective dose, particularly in elderly and/or debilitated, to preclude over-sedation. Meprobamate is metabolized in the liver and excreted by the kidney, to avoid excess accumulation exercise caution in its use in patients with compromised liver or kidney function. Meprobamate occasionally may precipitate seizures in epileptic patients. It should be prescribed cautiously and in small quantities to patients with suicidal tendencies.

AOVERSE REACTIONS:
ASPIRIN: May cause epigastric discomfort, nausea, and vomiting. Hypersensitivity reactions, including urticaria, angioneurotic edema, purpura, asthma, and anaphylaxis may rarely occur. Patients receiving large doses of salicylates may develop tinnitus.

MEPROBAMATE: CNS: Drowsiness, ataxia, dizziness, slurred speech, headache, vertigo, weakness, paresthesias, impairment of visual accommodation, euphoria, overstimulation, paradoxical excitement, fast EEG activity.

GI: Nausea, vomiting, diarrhea.

CARDIOVASCULAR: Palpitation, tachycardia, various forms of arrhythmia, transient ECG changes, syncope, hypotensive crisis.

ALLERGIC OR IDIOSYNCRATIC: Milder reactions are characterized by itchy, urticarial, or erythematous maculopapuler rash, generalized or confined to the groin. Other reactions include leukopenia, acute nonthrombocytopenic purpura, petechiae, ecchymosas, eosinophilia, peripheral edema, adenopathy, fever, fixed drug eruption with cross-reaction to carisoprodol, and cross-sensitivity between meprobamate/mebutamate and meprobamate/carbromal. Rare, more severe hypersensitivity reactions include hyperpyrexia, chills, angioneurotic edema, bronchospasm, oliguria, and anurie. Also, anaphylaxis, exfoliative dermatitis, stomatitis, and proctitis. Stevens-Johnson syndrome and bullous dermatitis have occurred.

HEMATOLOGIC (SEE ALSO "ALLERGIC OR IDIOSYNCRATIC"): Agranulocytosis, aplastic anemia have been reported, although no causal relationship has been established, and thrombocytopenic purpura.

OTHER: Exacerbation of porphyric symptoms.

DOSAGE ANO AOMINISTRATION:
Usual dose is one or two tablets, 3 to 4 times daily as needed for relief of pain when tension or anxiety is present. Not recommended for patients 12 years of age and under.

OVEROOSAGE:
Treatment is essentially symptomatic and supportive. Any drug remaining in the stomach should be removed. Induction of vomiting or gastric lavage may be indicated. Activated charcoal may reduce absorption of both aspirin and meprobamate. Aspirin overdosage produces usual symptoms and signs of salicylate intoxication. Observation and treatment should include management of hyperthermia, specific parenteral electrolyte therapy for ketoacidosis and dehydration, watching for evidence of hemorrhagic manifestations due to hypoprothrombinemia which, if it occurs, usually requires whole-blood transfusions. Suicidal attempts with meprobamate have resulted in drowsiness, lethargy, stupor, ataxia, coma, shock, vasomotor and respiratory collapse. Some suicidal attempts have been fatal. The following data, reported in the literature and from other sources, are not expected to correlate with each case (considering factors such as individual susceptibility and length of time from ingestion to treatment), but represent usual ranges reported. Acute simple overdose (meprobamate alone): Death has been reported with ingestion of as little as 12 grams meprobamate and survival with as much as 40 grams.

BLOOD LEVELS:
0.5-2.0 mg percent represents usual blood-level range of meprobamate after therapeutic doses. The level may occasionally be as high as 3.0 mg percent.

3-10 mg percent usually corresponds to findings of mild-to-moderate symptoms of overdosage, such as stupor or light coma.

10-20 mg percent usually corresponds to deeper coma, requiring more intensive treatment. Some fatalities occur.

At levels greater than 20 mg percent, more fatalities than survivals can be expected.

Acute combined overdose (meprobamate with other psychotropic drugs or alcohol): Since effects can be additive, history of ingestion of a low dose of meprobamate plus any of these compounds (or of a relatively low blood or tissue level) cannot be used as a prognostic indicator.

In cases of excessive doses, sleep ensues rapidly and blood pressure, pulse, and respiratory rates are reduced to basal levels. Any drug remaining in stomach should be removed and symptomatic treatment given. Should respiration or blood pressure become compromised, respiratory assistance, CNS stimulants, and pressor agents should be administered cautiously as indicated. Diuresis, osmotic (mannitol) diuresis, pentoneal dialysis, and hemodialysis have been used successfully in removing both aspirin and meprobamate. Alkalinization of the urine increases excretion of salicylates. Careful monitonng of urinary output is necessary, and caution should be taken to avoid overhydration. Relapse and death, after initial recovery, have been attributed to incomplete gastnc emptying and delayed absorption.

HOW SUPPLIED:
Scored tablets, bottles of 100; Redipak® strip pack 25's; Redipak® unit dose 100's; individually wrapped.

CI 3343-1 9/6 83

Wyeth Laboratories
Philadelphia, Pa. 19101

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ACS Professorships of Clinical Oncology

LaMAR S. McGINNIS, M.D., F.A.C.S., *Decatur**

EARLY IN THE LAST DECADE, the American Cancer Society established a program of professorships of clinical oncology in an effort to (a) bring about more effective management of cancer patients by improving cancer teaching in medical schools and other appropriate institutions at undergraduate, graduate, and continuing education levels; (b) extend the benefits of such teaching to both students and practitioners of the medical, dental, nursing, and allied professions; and (c) foster cooperation of all relevant medical and scientific disciplines in the management of cancer.

Some of the most outstanding leaders in cancer education have held these chairs at intervals since the inception of the program. Presently, 17 professors from a wide variety of oncologic disciplines hold these posts in academic institutions throughout the nation. Grants to fund these appointments are made by Boards of Directors of divisions of the American Cancer Society. The Georgia Division made a commitment to develop such a program in our state beginning in 1975; however, funds were not available. In 1979, the Division began to solicit an unrestricted gift to fund the program; and as a result of our affiliation with the United Way in 1981, funds were made available for two professorships at our two fully operational 4-year schools of medicine.

The need is great, our expectations are high, and our anticipation keen.

We now announce with great pride and considerable expectation the establishment of a professorship of clinical oncology at the Emory University School of Medicine and at the Medical College of Georgia. Charles M. Hugeley, M.D., Professor of Medicine at Emory, and Robert H. Johnson, M.D., Professor of Surgery at the Medical College of Georgia, will hold these appointments.

Dr. Hugeley, well known to all, has been a member of the faculty at Emory since 1948, and Professor of Medicine and Director of the Division of Hematology and Oncology since 1967. He has had a distinguished career as a leader in the generic area of oncology, has headed cancer training center efforts at Emory, has been active in both clinical and research areas related to cancer, and has the respect and endorsement of the community of oncologists nationwide. George Brumley, In-

* Dr. McGinnis is a general surgeon and Chairman of the Executive Committee, Georgia Division, American Cancer Society. Send reprint requests to him at 365 Winn Way, Ste. 201, Decatur, GA 30030.

Prepared at the request of the Georgia Division, American Cancer Society. Others wishing to contribute papers to this Page are invited to send them to Gray T. Fountain, MD, 910 North Jefferson, Albany, GA 31708.

terim Dean at Emory, said in announcing Dr. Hugeley's appointment, "I expect the American Cancer Society Professorship of Clinical Oncology to be the focus of our cancer-teaching program. Dr. Hugeley has been a vital force in the development of many of Emory University's cancer programs. The professorship fits in with our plans to build an outstanding cancer center at Emory."

Dr. Johnson, following post-residency training at M. D. Anderson and at the National Cancer Institutes, and faculty appointments at the University of Maryland, came to the Medical College of Georgia in 1974 as Professor of Surgery and Head of Surgical Oncology. The Chairman of the Surgery Department described Dr. Johnson as "an in-depth thinking clinician; a quiet and effective planner, who has the confidence of this faculty, that given promised support as indicated, will develop an exemplary cancer care and teaching program at the Medical College of Georgia." Fairfield Goodale, M.D., Dean of the Medical College, said, "Dr. Robert Johnson was chosen by this school as its nominee because of his total dedication to cancer care and education. His dedication to the cancer patient is exemplary. Dr. Johnson is an in-depth thinking clinician and an effective planner who has the confidence of his peers. I am confident he will develop an excellent cancer and teaching program at the Medical College of Georgia."

Dr. Johnson's initial interest is in the establishment of a conjoined cancer clinic and in the compilation of a comprehensive cancer curriculum to affect all 4 years of the M.D. curriculum. Dr. Hugeley will become the focal point of all cancer teaching at Emory and will be responsible for coordinating all clinical cancer training programs, and for developing additional teaching modalities to complement existing training in cancer and cancer-related diseases. Each school has pledged time, space, and secretarial and clerical support for these appointees.

Needless to say, the Georgia Division of the ACS is excited about the potential for these professorships. Our requirements for these appointees emphasize the need that time be freed from former duties to allow concentration on the objectives of the professorship. Increased emphasis on cancer teaching in the curriculum of all involved student groups and increased emphasis on the multidisciplinary approach to cancer care will hopefully be the outcome of these appointments.

The need is great, our expectations are high, and our anticipation keen. We await the future with considerable interest and will encourage our professors to use this space to keep the medical community informed of their plans and progress.



heart page
heart page
heart page

Hyperventilation Syndrome Simulating Ischemic Heart Disease

G. E. KING, M.D., *Augusta**

With the focus of attention being placed on the evaluation of patients presenting with chest pain with a view to coronary bypass surgery, the possibility of the presenting symptoms being somatic manifestations of an anxiety-depressive reaction seems too often to have become a consideration only after the results of an expensive cardiac evaluation prove to be normal.

Case Report # 1

P.G. is a 59-year-old widowed grandmother who has attended Talmadge Hospital for many years with multisystem problems which include a history of episodes of palpitations, shortness of breath, chest pain with an aching quality not related to exertion but often brought on by noise and bustle. Associated with these symptoms are a sensation of flushing of the face, headache, light-headedness, and tingling in both hands and feet, particularly on the left side. Many of these features were not elicited in the initial interview, and she was suspected of having coronary arterial disease. Coronary angiography showed a normal coronary arterial tree and normal ventriculogram. The diagnosis of hyperventilation syndrome secondary to chronic anxiety-depressive reaction was subsequently made. The social history revealed that all her housework and most of her cooking are done by her daughters on a formal rotating basis. In repeated interviews, no specific cause for her anxiety-depressive reaction could be identified and despite firm reassurances about her heart, she has made little progress in the 5 years that she has been followed.

Case Report # 2

P.B. was a 39-year-old police officer who complained of occasional "skipped beats." This irregularity would precipitate episodes of light-headedness, shortness of breath, discomfort in the chest together with a sense of constriction in the throat associated with difficulty in swallowing. His father and an uncle had ischemic heart disease. Social history revealed both work and marital problems. The exercise test results were equivocal but angiograms showed a normal coronary tree. When seen some years later, he was divorced, and the work problems had been resolved. The presenting symptoms had disappeared after the initial reassurance about his heart.

Variability of Autonomic Responses

In the normal individual, the "flight or fight" autonomic response to a genuine

* Dr. King is with the Division of Cardiology, Department of Medicine, Medical College of Georgia, Augusta, GA 30912.

Articles for this Page are sponsored and approved by the American Heart Association, Georgia Affiliate. Those wishing to contribute papers to this Page are invited to send them to Dr. Laurence O. Watkins, "Heart Page" Editor, Section of Cardiology, Dept. of Medicine, MCG, Augusta, GA 30909.

emergency situation produces awareness of a pounding heart, cold tingling skin, and a need for deep sighing respiration.[1, 2] In the neurotic, the threshold of this response is lowered, often to the point where the patient may not admit of any obvious anxiety-producing circumstance. The response may be exaggerated but, more importantly, may be extended in time. The immediate response, causing an awareness of the heart beat, focuses attention on the heart and in some cases may be reinforced by awareness of a decrease in skin perfusion. The increased and extended drive to respiration results in the development of the manifestations of hyperventilation syndrome, many features of which may be misinterpreted by the patient as evidence for heart disease.[3] This is more frequent if the patient knows something of the manifestations of ischemic heart disease from reading popular journals or is acquainted with someone with genuine heart disease.

Symptoms and Mechanisms

Hyperventilation results in a shift in blood pH as the Henderson-Hesselbach buffer mechanism fails to cope with the loss of carbon dioxide. The rise in blood pH by direct and indirect mechanisms produces further cardiovascular effects as well as changes in the threshold of excitable tissues. A generalized fall in peripheral vascular resistance, leading to increased venous return and to an increased stroke volume, heightens the patient's awareness of the heart beat. The resultant fall in blood pressure gives rise to dizziness and may be severe enough to cause actual syncope. Pounding headaches may also occur.

The shift in blood pH alters the level of ionization of serum calcium to cause an increased excitability of both cardiac and nerve tissue. This gives rise to frequent extrasystoles, usually ventricular in origin.

The increase in excitability of nerve tissue results in numbness and paresthesia with a characteristic distribution. Numbness and/or "pins and needles" involve the arms and legs particularly in the distal regions, the hands and feet.

In common with other somatic manifestations of anxiety-neurosis syndromes, the distribution is more frequently on the left side of the body, a phenomenon that is not related to handedness and is at present unexplained.[4, 5, 6] Numbness of the lips and gums is rare but also typical.

The exertion of continued hyperventilation will produce a generalized aching of the chest, often indefinitely localized to the sternum, but which is quite unlike the chest pain of angina.

A frequent symptom in these patients is globus hystericus, the pain of an intense spasm in the lower pharynx and upper esophagus. This is also a normal response to intense anxiety and perhaps better explained in the lay terms of being "choked with emotion." The symptom can be misinterpreted as anginal chest pain which radiates to the neck.

A mild costochondritis in the lower sternocostal junctions is also a frequent, simultaneous problem in these patients. This pain may be the root of the anxiety reaction since it reinforces the patient's concern that the pain might be cardiac in origin.[7]

Misdiagnosis

The combination of chest pain, shortness of breath, numbness and tingling of the left side of the body, and an awareness of a rapid heart beat are strongly suggestive to the patient that the heart is the seat of the problem, a conclusion that is too frequently seconded by physicians.

When the presenting symptoms are misdiagnosed as being due to angina and the patient is started on a Beta-blocking agent, there is, paradoxically, a relief of symptoms since most of the autonomic responses to anxiety are no longer manifest. These patients are also susceptible to placebo effects and thereby may also have a positive response to nitroglycerin. These apparent positive therapeutic responses often serve to confirm the mistaken diagnosis.

Diagnosis and Management

The syndrome occurs in all walks of life and in most age groups, but is most frequent in middle-aged females. The psychologic impact of the menopause may be the fundamental origin of the anxiety-depressive reaction in this patient group.

The diagnosis is usually clear enough, provided that the possibility is considered. The most consistent symptom is of paraesthesia of the hands, and this symptom should be routinely sought in the review of systems of all patients presenting with chest pain.

The "gold standard" for the diagnosis is the finding of a low pCO_2 in an arterial blood sample obtained during a spontaneous episode.[2] The symptoms can often be reproduced if the patient is urged to hyperventilate for several minutes.

It should be remembered that hyperventilation may cause acute T-wave inversions in the non-exercising patient. This may be used as a nonspecific diagnostic test.[8]

The results of other routine cardiac examinations should be normal. Any abnormality should be pursued vigorously, since the diagnosis of cardiac neurosis does not preclude coexistent coronary arterial disease. Indeed, in some cases, particularly in those with a positive family history, the neurotic manifestations may be an amplification of genuine early symptoms of coronary artery disease.

Provided that the results of physical examination, chest X-ray and EKG are normal, simple positive reassurance is usually all that is required to allay the symptoms in the majority of patients. An occasional patient will need exercise stress testing sometimes to evaluate a borderline EKG abnormality. This test may also be useful as a therapeutic measure to reinforce an assurance that there is no evidence for ischemic heart disease. In middle-aged women, because of the higher likelihood of a falsely positive electrocardiographic response to exercise, simultaneous thallium perfusion imaging should be considered.

A small proportion of patients fail to be convinced that they have no heart disease. This is frequently the case when the symptoms enable the patient to maintain a disabled lifestyle and thereby receive more care and attention than otherwise. In other patients, the anxiety-depressive reaction is chronic and deep-seated. Such patients also tend to be refractory to conventional psychotherapy.

Summary

Many patients presenting with chest pain have the cardiac manifestations of hyperventilation syndrome and globus hystericus as components of an anxiety-depressive reaction. Costocondritis and extrasystoles may precipitate a subacute neurotic reaction. The diagnosis of cardiac neurosis should be considered in the initial workup of the patient. Indirect questioning concerning the nature of the tachycardia, light-headedness, and particularly of changes in cutaneous sensibility should be a routine part of history taking in such patients and will often reveal typical symptoms.

Provided that all routine investigations are normal, symptomatic relief is usually given by positive reassurance. A small proportion of patients will fail to be reassured and will remain as difficult management problems.

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Federal Trade Commission Regulatory and Enforcement Activities Involving Professional Associations

ROBERT N. BERG, *Atlanta**

In 1975, the United States Supreme Court, in the landmark *Goldfarb* decision, held that activities undertaken by members of "learned professions" (e.g., physicians, attorneys, architects, engineers, accountants, etc.) were not immune from scrutiny under the antitrust laws.[1] Since that decision, federal and state antitrust regulatory authorities — most notably, the Federal Trade Commission (FTC) — increasingly have challenged the activities of health care professionals and institutions as being violative of the antitrust laws. As a result, many changes have occurred in the nature of various activities involved in the "health care delivery system" which had developed over the years preceding *Goldfarb*, in order to ensure compliance with the antitrust laws; in essence, physicians and hospitals have had to alter to some degree the way they practice medicine in order to satisfy the competitive standards of the antitrust laws.

The effects of the "injection of competition" into the health care industry have been felt by physicians at a different level as well. Over the past several years, the activities of trade and professional associations — including, specifically, the national, regional, and local physicians' associations — increasingly have been scrutinized by the FTC.[2] This, in turn, has required associations of health care professionals to re-think and restructure their activities in order to comply with the antitrust laws. From all signs, it appears that the FTC's scrutiny in this area will continue (efforts having failed to enact legislation designed to remove professionals and their activities from the jurisdiction of the FTC),[3] and, in fact, may increase. Accordingly, this month's Legal Page looks at the recent activities of the FTC in regulating trade and professional associations, and provides some insights as to the likely course of future FTC regulatory activities.

Trade and Professional Associations and The Antitrust Laws

Before reviewing the FTC's recent activities involving trade and professional associations, it is first appropriate to point out a few "basic facts of life" regarding the interplay between the antitrust laws and the role of trade and professional associations. One of the primary purposes of the antitrust laws is to promote free and unfettered competition by prohibiting joint activities among competitors, when those activities are intended to or have the effect of unreasonably restraining competition. Under the Sherman Act,[4] for example, a violation may occur if (i) two

* Prepared at the request of the Medical Association of Georgia. Mr. Berg is an associate in the firm of Powell, Goldstein, Frazer & Murphy, General Counsel to the Association, 1100 C & S National Bank Building, Atlanta, GA 30335.

or more persons or entities combine, contract, or conspire; and (ii) that combination, contract, or conspiracy, in either purpose or effect, unreasonably restrains trade. As an example, a group of competing manufacturers cannot enter into an agreement to raise or fix the prices at which they will resell their products,[5] or agree to refuse to resell their products to certain purchasers.[6]

From this, it can easily be seen why trade and professional associations are viewed with particular interest and come under close scrutiny by antitrust regulators. An association of professionals, by definition, *is* a combination of competitors; the actions taken by that association, by definition, *are* agreements or joint actions among competitors. Thus, one of the two elements necessary to establish a violation of the Sherman Act — a combination, contract, or conspiracy among competitors — will be present virtually in every case challenging the activities of trade and professional associations.

This does not mean that trade and professional associations, or the activities engaged in by those associations, are unlawful under the antitrust laws in every case. It does mean, however, that the members of those associations, as competitors, must be sensitive to the antitrust risks inherent in their activities, and must be particularly attuned to whether or not those activities may unreasonably restrain competition.

In essence, the members of trade or professional associations must keep in mind that activities which they could legitimately undertake as individuals (e.g., negotiating with a "purchaser" as to the price at which the professional's services would be sold) may be unlawful when that same activity is undertaken by a trade or professional association on the basis of an agreement or understanding among the various members of that association. Moreover, the likelihood of certain unlawful activities taking place is significantly enhanced when a trade or professional association is involved. For example, organized efforts by a trade or professional association to collect and disseminate to its members current or prospective pricing information may constitute unlawful price-fixing.[7]

Recent FTC Activities Involving Health Care and Professional Associations

Recently, the FTC has stepped up significantly its activities in the area of regulation of associations of health care professionals. In particular, the FTC has focused upon four types of activities: (1) Membership admission procedures and qualifications; (2) codes of ethics and advertising restrictions; (3) peer review activities; and (4) actions designed to impede or hinder cost containment efforts. Each of these areas is discussed briefly below.

Membership Requirements — The membership requirements of professional associations may come under antitrust attack when those requirements are used in order to impose unreasonable restraints on competition. Most often, this is true when membership in a particular professional association is required in order for a person to practice that profession.[8] When membership in an association is an "economic necessity," the antitrust laws do not permit the association to impose unreasonable membership requirements — denial of membership must be based upon legitimate, objective factors designed to promote, rather than to hinder, competition. The FTC's recent activities in this area have involved challenging membership requirements designed to limit membership to those professionals who engage in "ethical" practices. Examples of this type of requirement would be conditioning membership in a medical association upon a requirement that all members refrain from entering into agreements with HMOs or other types of organizations that provide alternative forms of health care delivery, or refrain from entering into employment relationships with hospitals other than on a fee-for-service basis.[9]

Codes of Ethics and Advertising Restrictions — The FTC has expressed a continuing concern in codes of conduct or ethics promulgated by health care associations. In addition to the FTC's well-publicized challenge to the AMA's

ethical restrictions on advertising and solicitation by physicians, the FTC has also challenged a host of other organizations in cases involving similar prohibitions.[10]

Peer Review Activities — The third area in which the FTC has shown an interest over the past few years relates to the peer review activities engaged in by medical associations. Specifically, the FTC has issued several advisory opinions sanctioning the performance of peer review by professional associations; in each of these advisory opinions, however, the FTC has gone to great lengths to caution the particular association involved as to the potential antitrust pitfalls which could arise if the program were to impose an unreasonable restraint on competition.[11]

Hindering Cost Containment Efforts — Finally, perhaps the area in which the FTC has shown the greatest involvement has been in challenging professional association actions motivated by or having the effect of unreasonably hindering or restraining cost containment efforts. For example, the FTC has challenged the actions of several dental associations, alleging that those actions were designed to frustrate the cost-containment efforts suggested by dental insurers.[12] The FTC also successfully challenged actions by a state medical society in jointly representing its members in negotiating with third-party payors, on the ground that the actions by the medical society constituted unlawful price-fixing and an unlawful boycott.[13]

The Future Course of FTC Regulatory Efforts

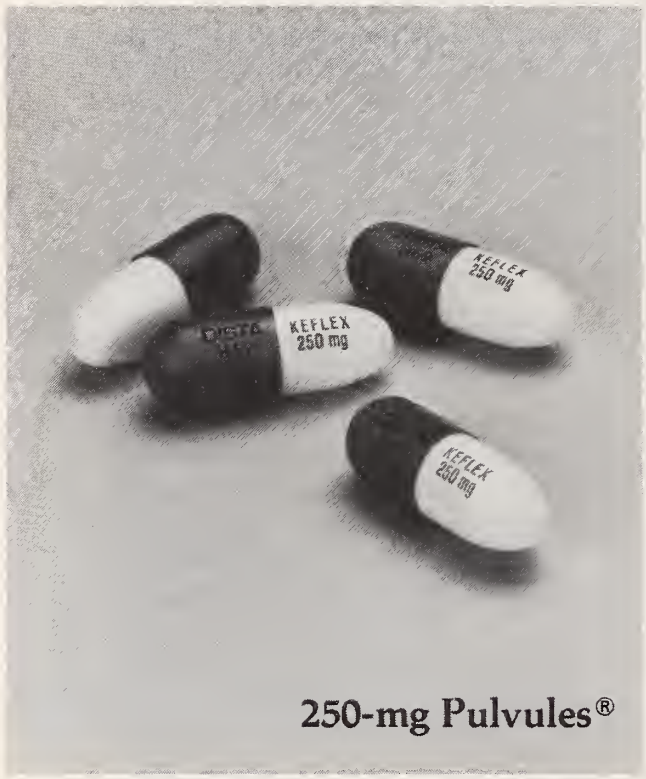
Based upon the increase to date in the FTC's regulatory activities involving health care professional associations and upon the willingness of courts to apply traditional antitrust principles to analyze the activities of health care providers and associations, it must be expected that the FTC's regulatory efforts in this area will continue to increase in the foreseeable future. This expectation is supported by remarks recently made by Timothy J. Muris, the Director of the FTC's Bureau of Competition, before the Conference on Representing Trade Associations, Practicing Law Institute, in Washington, D.C. After reviewing the FTC's recent activities involving trade and professional associations, Mr. Muris volunteered that: "We do intend, however, to be vigilant in this area [of regulating trade and professional associations] and to bring enforcement proceedings when serious anticompetitive consequences can be discerned. Indeed, judging from the last three months, association work promises to be a prominent part of Commission enforcement."

In turn, it must also be expected that the activities undertaken by trade and professional associations, such as MAG, will be shaped to a certain degree by the shadow cast by the FTC's increasing interest in scrutinizing those activities. Accordingly, just as individual physicians must assess the antitrust consequences of the health care activities they undertake as practicing physicians, a similar assessment must be made when those activities are undertaken by them as members of a professional association.

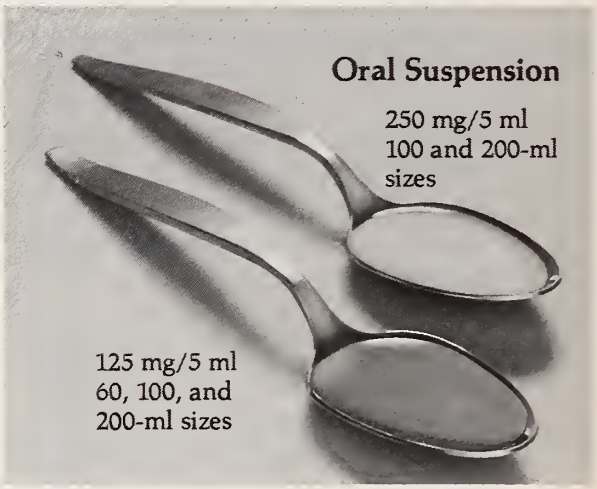
Notes

1. *Goldfarb v. Virginia State Bar,* 412 U.S. 773 (1975).
2. This increased scrutiny is evidenced, among other things, by the FTC's investigation of MAG actions involving podiatrists. This investigation, which commenced in 1979, is still in the investigative phase; no complaint has been issued against MAG by the FTC.
3. A Bill designed to exempt state-regulated professionals from the FTC's jurisdiction was passed by the U.S. House of Representatives on December 1, 1982. A similar Bill was defeated, however, by a vote of 59 to 37, in the United States Senate on December 17, 1982.
4. 15 U.S.C. §1.
5. See, e.g., *U.S. v. Trenton Potteries Co.,* 273 U.S. 392 (1925).
6. See, e.g., *Eastern States Retail Lumber Retailers Assn. v. U.S.,* 234 U.S. 600 (1914).
7. See, e.g., *Plymouth Dealers Assn. v. U.S.,* 279 F.2d 128 (9th Cir. 1960); compare, *Maple Flooring Mfrs. Assn. v. U.S.,* 268 U.S. 563 (1925).
8. See, e.g., *Arizona State Dental Assn. v. Boddicker,* 549 F.2d 626 (9th Cir. 1977).
9. See, *American Society of Anesthesiologists, Inc.,* Dkt. No. C-2952, 93 F.T.C. 101 (1979).
10. See, *American Dental Assn.,* Dkt. No. 9093, 100 F.T.C. 448 (1982); *Broward County (Florida) Medical Assn.,* Dkt. No. C-3091, 99 F.T.C. 622 (1982).
11. See, Advisory Opinion to American Podiatry Assn., issued on August 18, 1983; Advisory Opinion to Iowa Dental Assn., issued on April 3, 1982.
12. See, e.g., *Indiana Dental Association,* Dkt. No. C-2957, 93 F.T.C. 392 (1979).
13. *Michigan State Medical Society,* Dkt. No. 9129, 101 F.T.C. 191 (1983).

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Baxley, John B., III, Richmond — ACT — FP
1417 Pendleton Rd., Augusta 30904

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Breedlove, William D., Muscogee — I&R
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1700 E. Broad Ave., Albany 31705

Bush, Dwana M., MAA — ACT (N-2) — FP
5 Roswell Rd., NE, Ste. 147, Atlanta 30342

Cameron, E. Christian, MAA — ACT — IM
3280 Howell Mill Rd., NW, Atlanta 30327

Carroll, Robert, Dougherty — ACT — IM
803 N. Jefferson St., Albany 31701

Cone, Terry A., Muscogee — I&R — FP
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Cunanan, Linda C., Coweta — ACT (N-2) — IM
72 Greenville St., #7, Newnan 30263

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Dunbar, Mark R., MAA — I&R — OPH
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770 Pine St., Ste. 160, Macon 31201

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114 Mimosa Dr., Thomasville 31792

Fiandaca, Massimo S., MAA — I&R — NS
1281 Brockett Rd., Ste. 23-A, Clarkston 30021

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Medical Arts Bldg., Columbus 31906

Frady, Robert P., MAA — ACT (N-2) — EM
5161 Putnam Rd., Cohutta 30710

Gisness, Robert A., MAA — ACT (N-2) — EM
5406 Treelodge Pkwy., Dunwoody 30338

Glavey, Christine P., MAA — ACT (N-2) — D
6500 Vernon Woods Dr., NE, Ste. D-8, Atlanta 30328

Harper, William M., IV, Muscogee — ACT (N-2) — U
1021 Talbotton Rd., Columbus 31901

Hood, Jonathan C., Muscogee — I&R
The Medical Center, P.O. Box 951, Columbus 31994-2299

Hopkins, Charles T., Jr., MAA — I&R — ORS
80 Butler St., Dept. of Orthopedics, Atlanta 30303

Hopkins, Mark D., Peachbelt — Service
USAF Hospital, Robins Air Force Base, Warner Robins 31098

Horn, Warren B., Crawford W. Long — ACT — An
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P.O. Box 2787, Columbus 31994-3899

Huberdeau, Rene Marc, Troup — ACT — ORS
303 Smith St., LaGrange 30240

Johnson, Neal D., Muscogee — I&R
Dept. of Family Practice, Martin Army Hospital, Columbus 31905

Jones, Frank R., Muscogee — I&R
Martin Army Hospital, Fort Benning 31905

Jones, Mary B., Coffee — ACT — FP
3 Atlanta Ave., Nicholls 31554

Karsh, Richard B., Thomas Area — ACT — R/PDC
113 W. Hansell, Thomasville 31792

Lee, Louis G., Thomas Area — ACT (N-1) — IM/GE
503 Gordon Ave., Thomasville 31792

Leffert, Robert L., Crawford W. Long — ACT — PTH
St. Mary's Hospital, Athens 30606

Lochridge, John B., MAA — ACT (N-2) — P/CHP
5667 Peachtree Dunwoody Rd., NE, Ste. 335, Atlanta 30342

Loomis, Earl A., Jr., Richmond — ACT — P/CHP
1515 Pope Ave., Augusta

MacCaughelty, T. Cameron, Ogeechee River — ACT — AN
P.O. Box 567, Statesboro 30458

McLeod, Kevin, Muscogee — I&R
The Medical Center, P.O. Box 951, Columbus 31994-2299

Meyer, John D., MAA — ACTG — R
993-C Johnson Ferry Rd., NE, Atlanta 30342

Moore, John E., MAA — ACT (N-2) — TS/CD
272 Boulevard, NE, Atlanta 30312

Moorhead, Frankie L., MAA — Associate — PD
75 Piedmont Ave., NE, Ste. 470, Atlanta 30303

Moran, Michael P., Muscogee — I&R
The Medical Center, P.O. Box 951, Columbus 31994-2299

Moss, Richard N., Richmond — ACT — FP
1417 Pendleton Rd., Augusta 30904

Myers, Allen R., MAA — ACT — FP
1143 Alpharetta St., Roswell 30075

Navarro, Alfonso V., Peachbelt — Service — IM
USAF Hospital, Robins Air Force Base, Warner Robins 31098

O'Quinn, Mary H., Richmond — ACT (N-2) — PTH
3051 Wheeler Rd., Augusta 30910

Orr, Douglas W., MAA — ACT (N-2) — ON/HEM
993-D Johnson Ferry Rd., NE, Atlanta 30342

Patel, Bipin M., Muscogee — ACT (N-2) — IM/PUD
St. Francis Medical Park, 2300 Manchester Exway., Columbus 31904

Patel, Hasmukh R., Whitfield-Murray — ACT (N-2) — IM/GE
1217 Memorial Dr., Ste. 1, Dalton 30720

Pitts, Stephen R., MAA — I&R — IM
1131 Rogers St., Clarkston 30021

Plemons, Michael R., Clayton-Fayette — ACT (N-2) — DR
119 Upper Riverdale Rd., P.O. Box 699, Riverdale 30274

Powell, Michael F., McDuffie — ACT (N-2) — IM
604 Ware St., Thomas 30824

Rainer, Joel H., MAA — I&R — CD
Grady Memorial Hospital, Atlanta 30335

Rauth, Virginia A., MAA — ACT (N-2) — TR
5665 Peachtree Dunwoody Rd., NE, Atlanta 30342

Rouben, David P., MAA — ACT (N-2) — TR
315 Boulevard, NE, Atlanta 30312

Sanchez, George L., Muscogee — I&R
The Medical Center, P.O. Box 951, Columbus 31994-2299

Scherr, John M., MAA — ACT (N-1) — IM
105 Collier Rd., NW, Ste. 4030, Atlanta 30309

Sehgal, Narinder N., Richmond — ACT — OBG
1350 Walton Way, Augusta 30901

Shadeed, Baheeg L., MAA — ACT (N-2) — GS
1776 Old Spring House Lane, Atlanta 30338

Smith, Diane K., Richmond — ACT — IM
Medical College of Georgia, BD 101, Augusta 30912

Somogyi, James W., MAA — ACT — R/NM
Dept. of Nuclear Medicine, Georgia Baptist Medical Center, Atlanta 30312

Spiegl, Paul V., MAA — ACT (N-2) — ORS
5667 Peachtree Dunwoody Rd., NW, Ste. 150, Atlanta 30342

Stockstill, J. Dean, Muscogee — I&R
The Medical Center, P.O. Box 951, Columbus 31994-229

Stout, Alan W., Muscogee — I&R
The Medical Center, P.O. Box 951, Columbus 31994-2299

Suhge d'Aubermont, Peter C., MAA — ACT (N-2) — D
5667 Peachtree Dunwoody Rd., NE, Ste. 330, Atlanta 30342

Thomas, Jerry L., Muscogee — I&R — FP
The Medical Center, P.O. Box 951, Columbus 31994-2299

Turrentine, John E., MAA — ACT (N-2) — OBG
35 Collier Rd., NW, Ste. 230, Atlanta 30309

Vecchio, John J., Peachbelt — ACT — U
Ste. A, Doctors Bldg., 212 Hospital Dr., Warner Robins 31093

Venable, Roger J., Richmond — ACT (N-2) — FP
1417 Pendleton Rd., Augusta 30904

Wagner, George C., Flint — ACT — IM
406 Fourth Ave., E, Cordele 31015

Walus, Michael A., Whitfield-Murray — ACT — NS
1207 Moice Dr., Dalton 30720

Ward, John R., Washington — ACT — GS
522 Washington Ave., Sandersville 31082

Wayne, Barry A., Muscogee — I&R
The Medical Center, P.O. Box 951, Columbus 31994-2299

Weissman, Evelyn L., Jefferson — ACT — GS
1067 Peachtree St., Louisville 30434

Weissman, Ira M., Jefferson — ACT — PD
1067 Peachtree St., Louisville 30434

Wells, Charles C., Bibb — ACT (N-1) — N
740 Hemlock St., Macon 31201

West, Roger G., MAA — I&R — R
1365 Clifton Rd., NE, Atlanta 30322

Woodhams, J. Trevor, MAA — ACT (N-2) — OPH
3280 Howell Mill Rd., NW, Ste. 101, Atlanta 30327

Woodward, Bolan P., South Georgia — ACT (N-2)

— OBG
2704 N. Oak St., Valdosta 31602

Worsley, Norman E., II, Peachbelt — ACT (N-2) — AN
416 Lake Front Dr., Warner Robins 31093

PERSONALS

Second District

Usup Choi, M.D., of Albany, and **Stephen Clements Allen, M.D.,** of Moultrie, have been initiated into the Fellowship of the American College of Surgeons.

Fifth District

Atlanta intern/cardiologist, **Bernard S. Lipman, M.D.,** co-authored a chapter of *MacBryde's Signs & Symptoms* which was recently published by J. B. Lippincott. The title of the chapter is "Clubbed Fingers and Hypertrophic Osteoarthropy." He is a recipient of the Year Book Medal for distinguished service and his contribution to medical literature.

Sixth District

Thomas A. Sappington, M.D., of Thomaston, retired in December of 1983. Some of the many highlights of his career are: President, Georgia Academy of Family Physicians, 1970; Family Physician of the Year — MAG, 1971; Charter Member of American Board of Family Practice, 1973; Received Excellence in Teaching Award from residents of Department of Family Practice, MCG, 1979; Established Thomas A. Sappington, College Scholarship Fund, Georgia Academy of Family Physicians, 1979; Dedication of Thomas A. Sappington Library, Department of Family Practice, MCG, 1981. Dr. Sappington exemplifies a leader in his professional affairs and a leader in his community. He has dedicated his life to family medicine and exemplifies the meaning of quality care through caring.

Seventh District

Charles R. Underwood, M.D., a general surgeon from Marietta, was appointed a Director on the Georgia Hospital Association Board.

Ninth District

The Northeast Georgia Medical Center has announced officers of the 1984 staff. They are: **Larry Morris, M.D.,** pediatrician, Chief of Staff; **William T. Langston, M.D.,** pediatrician, Vice-chief of Staff; and **Daniel Luke, M.D.,** a family practitioner, Secretary-Treasurer.

Robert Stahlkuppe, M.D., has moved his practice of family medicine from Tucker to Haiwassee.

Two Commerce physicians were elected 1984 officers of the Forsyth County Hospital: family practitioner **Shannon Mize, M.D.,** president, and internist **J. Fred Boling, M.D.,** vice president.

Tenth District

Augusta surgeon, **Louie H. Griffin, Jr., M.D.,** was elected president of the University Hospital medical staff for 1984. Other officers are **Nesbit M. Dasher, M.D.,** president-elect; **David W. Cundey, M.D.,** secretary; **Ronald F. Galloway, M.D.,** vice president, professional service division; **Harry Sherman, M.D.,** vice president, patient care services I; and **Michael Shlaer, M.D.,** vice president, patient care services II.

SOCIETIES

Participating in Georgia's Semiquincentenary celebration, the **Georgia Medical Society** presented a plaque on December 4, 1983, remembering its historic contributions to the Mayor and the City of Savannah. The inscription on the plaque, pictured below, reads as follows:

THE GEORGIA MEDICAL SOCIETY

The first Medical Society of Georgia, sixth oldest in America, was organized June 28, 1804, and continues to be active in Savannah today. Dr. Noble Wimberly Jones, first President, was the son of a member of General Oglethorpe's first settlers of 1733.

Dr. Samuel Roberio Nunez, first practicing physician, arrived July 10, 1733, with the second expedition to the new colony. He arrived in time to treat successfully a raging epidemic of dysentery.

In 1740, the first clinic for the poor opened at nearby Bethesda under Dr. John Hunter and Reverend George Whitefield, who previously had founded America's oldest orphanage there.

The Georgia Medical Society adopted the state's first Code of Medical Ethics, achieved a program of systematic vaccination against small pox, carried out health surveys of Savannah and surrounding counties, founded a Medical Library, formed the first systematic anti-malarial effort begun in the United States, and conducted extensive studies of Savannah's major epidemic diseases — malaria, yellow fever, and small pox.

DEDICATED BY THE GEORGIA MEDICAL SOCIETY, DECEMBER 1983.



Attending the dedication of the plaque to the City of Savannah are (left to right) Dr. John B. Rabun, 1983 President of the Georgia Medical Society; Mr. Walter C. Corish, Jr., Alderman of the City of Savannah representing the Mayor; Dr. Eloise B. Sherman, 1st Vice President of the MAG and Past President of the Georgia Medical Society; A. Preston "Alex" Russell, Jr.; Dr. A. Preston Russell, a pathologist and historian of the Georgia Medical Society (he portrayed the part of General Oglethorpe); and Dr. J. Patrick Evans, 1983 Vice President of the Georgia Medical Society.

DEATHS

Mercer Carter Blanchard, M.D.

Mercer Carter Blanchard, of Columbus, died January 17 at age 66. Dr. Blanchard practiced medicine in Columbus for 35 years. He was a graduate of Johns Hopkins University. He served in the U.S. Medical Corps in Japan during the occupation following World War II. Dr. Blanchard was a research fellow in infectious diseases at Children's Hospital in Philadelphia and the Sidenham Hospital in Baltimore before returning to Columbus.

Survivors include his wife, four daughters, and four grandchildren.

Richard A. Dodelin, M.D.

Columbus Orthopaedic Surgeon, Richard A. Dodelin, 62, died January 2. Dr. Dodelin was one of the first orthopaedic surgeons to practice in Columbus. He graduated from Emory University School of Medicine, completed his internship at Grady Memorial Hospital and his residency in orthopaedic surgery at Duke University School of Medicine.

Dr. Dodelin is survived by his wife, two daughters, one son, one sister, and six grandchildren.

Peter Carl Graffagnino, M.D.

Peter Carl Graffagnino died January 18 in Columbus. Dr. Graffagnino was 67. He served 5 years in the U.S. Army medical corps during World War II as a major. Dr. Graffagnino was a graduate of Tulane University. He did his post-graduate training at Charity Hospital in New Orleans, at Cornell Hospital in New York, and at Johns Hopkins University, Baltimore. He was active in the Southern Medical Association; American Medical Association; Alpha Omega Alpha and Southeastern OB/GYN Society; a Fellow of the American College of Surgeons; and the American College of Obstetricians and Gynecologists. He was president of the Muscogee County Medical Society in 1962 and president of the St. Francis Hospital staff in 1972.

Survivors include his mother, his wife, two sons, a brother, and four grandchildren.

Hoke Wammock, M.D.

Hoke Wammock, aged 78, died January 9. Dr. Wammock was retired director of Enoch Callaway Cancer Clinic in LaGrange. He graduated from the Medical College of Georgia and received his training in cancer treatment in Philadelphia. He served as director and chief surgeon at Jeanes Cancer Hospital in Philadelphia. He was professor of Oncology and Surgery at the Medical College of Georgia from 1948 until 1962. Dr. Wammock served on the Board of Directors of the American Cancer Society of Troup County and the Georgia Division.

He is survived by his wife, one daughter, one son, and four grandchildren.

Mark Brown, M.D.

Mark Brown, Professor of Radiology and Chief of Nuclear Medicine at the Medical College of Georgia, died November 19, 1983, in Augusta.

During his 23 years at the Medical College, he made many significant contributions. The Department of Radiology experienced considerable growth under his chairmanship from 1963 to 1973. Dr. Brown was highly respected as a teacher by his demonstrated thoroughness in patient care. His areas of research included neutron radiography, general diagnostic radiology, and nuclear medicine. He was instrumental in the development of the Georgia Radiation Therapy Center.

Dr. Brown received his M.D. degree from Vanderbilt University in 1950 and served his residency at the Mallinckrodt Institute of Radiology, Barnes Hospital-Washington University. He was a diplomate of the American Board of Radiology and the American Board of Nuclear Medicine. He was elected as a Fellow in the American College of Radiology and as a counselor in the Radiological Society of North America.

Dr. Brown is survived by his wife and three daughters.

Committee Activities . . .

Highlights — MAG Board of Directors' Meeting — January 15, 1984

Department of Medical Assistance — Dr. Moore reported that he had received a letter from the Department of Medical Assistance, advising the Medical Association of Georgia of their selection for the Physician Advisory Committee and the Hospital-Based Physician Advisory Committee.

Health Policy Agenda — Joseph F. Boyle, M.D., President-Elect of the AMA, will speak to the MAG House of Delegates in April and provide information on the AMA Health Policy Agenda.

Report of the Executive Director — Ms. Sherry Waronker was introduced as the newest addition of the MAG staff. She is Assistant Director of Public Relations.

Committee on Committees — At the February, 1983, meeting of the Executive Committee, a Committee on Committees was approved to examine the MAG committee structure and recommend changes to make it better serve the needs of MAG. J. Rhodes Haverty, M.D., Chairman of the MAG Committee on Committees, presented the report that the committee intends to submit to the 1984 House of Delegates for approval. By consensus, the Board received this report as information.

Public Health Committee — The Chairman of the Department of Human Resources (DHR) Subcommittee on Public Health presented a report on the plan to implement the 1982 Georgia Community Care for the Elderly Act. The Committee recommended that MAG support the concept of this program and asked the DHR for additional funds for the physician member of the assessment team.

Public Health Education and Screening — The Public Health Committee recommended that MAG support the concept of health education and screening by contacting the business coalitions and educating them as to the benefits of such screening programs and urged the MAG county medical societies to work with their local major business-medicine coalition to conduct the screening program. The Board voted to refer the recommendations of the Public Health Committee to the Medical Practice Committee for their recommendations — particularly relative to the appropriateness of this method of conducting screening programs.

State Funding, Medication for Public Health Programs — The Board approved contacting DHR in support of additional funds for the purpose of purchasing the amount of medication needed to adequately treat those persons in DHR programs for hypertension, diabetic control, and family planning.

Impaired Physicians Committee — The Chairman of this Committee requested MAG for computer time in order to do a computerized study of factors that may be influencing a higher percentage of anesthesiologists than other specialists enrolled in Georgia's Impaired Physicians Program. This research study will encompass 800 patients and will be made over a period of 2 years. The Board granted approval of this request.

Henry County Medical Society — The Board granted the request of physicians in Henry County to become a separate county medical society.

Committee on Legislation — *Adult abuse:* The Georgia Academy of Family Physicians requested MAG's support for legislation requiring reporting abuse to disabled adults. The Board voted MAG support of the concept of such legislation. It was understood by the Board that civil and criminal immunity is provided to those who report in good faith cases of adult abuse.

Committee on Nursing — As part of its effort to help alleviate the nursing shortage in hospitals, the MAG/GNA Joint Practice Committee proposes a resolution to establish joint or collaborative practice in hospitals. The Chairman of the committee felt that local voluntary development of Joint Practice Committees in hospitals would enhance the nurses' job satisfaction by improving nurse/physician communication and ultimately patient care. The Board referred this resolution to MAG counsel and the Committee on Legislation for further study.

Medical Practice Committee — The Board approved the following position statement of the Medical Practice Committee on the definition of private practice:

> "The private practice of medicine is defined as delivery of medical care carried out in a direct personal relationship in which direct responsibility for care and payment exists between the patient and physicians. MAG supports the environment which allows for maximum freedom of choice for both the patient and physician to select the location of the delivery of care, alternatives of treatment and method of payment for services rendered."

The Committee emphasized that it does not think it appropriate to label physicians, but that MAG should stress the importance of a personal agreement between the patient and the physician as opposed to direct contract between the physician and third party payers without actual patient involvement.

At the Committee's recommendation, the Board voted to instruct the AMA delegation to continue speaking with the AMA to keep the HFCA from totally implementing the DRG program without appropriate study.

Public Relations Committee — The Board directed the PR Committee to continue to work to advance the cause of private practice by a PR campaign to promote the principals and policies of medicine as enunciated by MAG.

Georgia Medical Care Foundation — At its meeting in December, 1983, the Executive Committee took under advisement a matter pertaining to the Georgia Medical Care Foundation's (GMCF) anticipated plan outlining specifics by which it will fulfill the requirements of the Contractor under the PRO contract soon to be awarded. It was pointed out that the Foundation would appoint a committee whose job would be to design review proposals and translate the requirements to be imposed by the

Federal Government into a specific review process to be administered by the Foundation. As MAG's Liaison Committee with GMCF, the Executive Committee at that time appointed the following to represent MAG on the GMCF Advisory Council: M. D. Pittard, M.D., Toccoa; Ollie O. McGahee, M.D., Jesup; W. Earl Bobo, M.D., Decatur; Harry N. Dorsey, M.D., Albany; George J. Everidge, M.D., Columbus; and Bob G. Lanier, M.D., Atlanta.

MAG Mutual Insurance Company — The President of MAG Mutual reported on its activities and goals. In all aspects, it is advancing rapidly: at the end of 1983, there were 1700 MAG Mutual insured physicians; the new data processing system is operational; the company has moved to larger quarters at 731 W. Peachtree Street in Atlanta; there are 27 trained professional insurance people on staff; the company reached its anticipated goal of $3,000,000 in invested surplus and was able to discontinue the Surplus Certificate offering. It was reported that MAG Mutual expected a rate increase February 1, 1984, as a sound business action recommended by its business actuaries.

Risk Management Seminars — It was reported that the Risk Management Program in Georgia has become a model for many in the country. It was understood that the Second Series of Risk Management Seminars would start next month with orientation of specialties.

(Continued from page 159)

The $200 was put "on hold," and the Auxiliary waited for the new renovations to be completed. These being finished, early in January of 1984, just before the General Assembly met on the ninth, more measurements, more outlines of the floor space and wall space were obtained.

Having gotten the necessary data, Judy Jones, President of the AMAG, Barbara Thibodeaux, immediate past president, and Barbara Tippins, legislative chairman, met on an overcast, snow-threatening day in January, purchased five framed prints and personally hung them on the walls of the reception and examining rooms.

Another problem now existed — a wall of beautiful, empty shelves in the reception room with nothing to grace them. The funds were exhausted but imagination and a little ingenuity produced a collection of items — a basket of pine cones, sea shells from the beaches, a silk prayer plant growing out of a neat little basket, silk lilies and small twigs of pussy willow arranged in a low mass of color, a silk coleus plant in a bright coffee mug, a brass bird perched on a limb, a hand painted wooden duck, and some other small items — to be used for this purpose.

All of these added to the color and warmth of the room, but there is space for other things on the shelves, as well as the need for other accessories in the rooms; a privacy curtain or screen could be utilized. Ah, another challenge for another day.

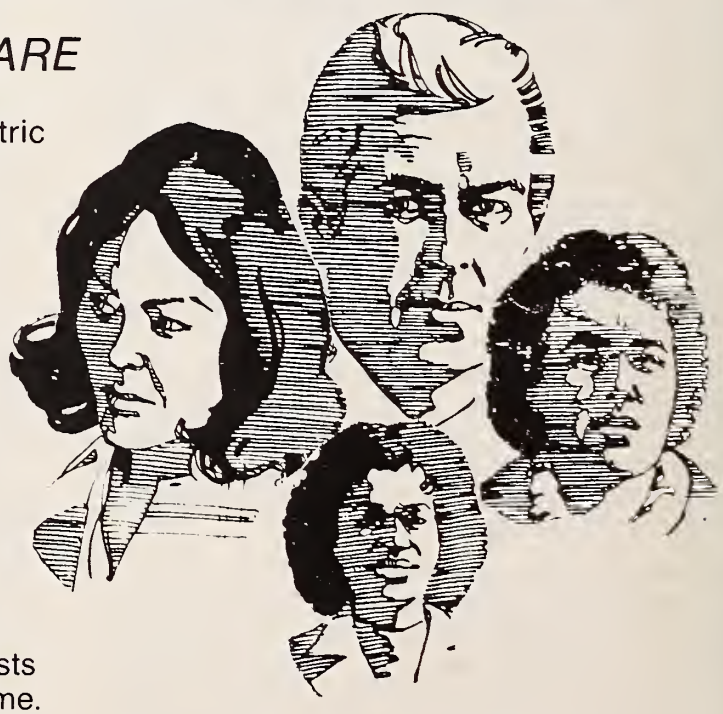
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A Temporal Muscle Fascia Graft for the Traumatic Nose

Case Report

A white female, age 21, came to me with an old nasal fracture from an automobile accident, and not only did she give a history of breaking her nose, but also of her nose breaking the steering wheel. She was told that, according to her x-rays, her nose had not been fractured. So she was dismissed. On examination several months later, not only was her nose spread quite wide but she had extensive cartilage tearing that involved the alar cartilages, the upper lateral cartilages, quadrilateral cartilage, and nasal septal cartilage with 90% obstruction. She was admitted to the hospital, and a septoplasty, rhinoplasty, (i.e., nasal reconstructive surgery), and a lateral fracturing of the inferior turbinates were performed. The rhinoplasty consisted of removing the superior borders of the nasal bones, lateral osteotomies, and insertion of a precolumnella strut. The intra-alar incisions revealed that the cartilage was not only pinched inward but it also had undergone fibrous degenerative changes. The quadrilateral cartilage was almost totally destroyed. The skin over the lower lateral cartilage was indurated and pinched inward. A large egg-shaped piece of fascia was taken from the left temporal muscle, folded over to fit the contour of the nose, and carefully placed over the remaining cartilagenous structure.* The result was excellent. The skin no longer has that indurated appearance.



Before



After

Comments

(1) I recommend starting a fascia bank.

(2) I have kept cartilage in a refrigerator (not frozen), in a half aqueous merthiolate and half normal saline for grafting for years, and on one occasion, six rather large grafts were used to fill in a traumatically crushed nose with excellent results.

(3) There have been no rejections.

(4) Cartilage grafts over the cartilage area have not been as satisfactory, as they have a tendency to curl and cause further deformity.

(5) X-rays of the nose are not always dependable. Cartilage tears are much harder to correct and more serious than fractured nasal bones and nasal maxillae.

(6) Nothing beats a careful nasal examination.

(7) I see nothing in the literature of a temporal graft being used in the nose.

(This case was presented before the Surgical Staff Conference at Coliseum Park Hospital in Macon, September 6, 1983, by William L. Barton, M.D., an otolaryngologist.)

* This procedure had been suggested by Dr. William H. Holden, my former Senior Attending at Columbia Presbyterian Medical Center, New York City, several years ago. At that time, a small piece of fascia graft was removed from the left temporal muscle and was used to fill in a small alar deformity.

Physician's Recognition Award Recipients

LISTED BELOW *are those physicians in Georgia who have earned the AMA's Physician's Recognition Award (PRA) from October through December, 1983.*

The Award was established in 1969 "to recognize, encourage, and support physicians who participate regularly in continuing medical education and to emphasize the importance of developing more meaningful continuing medical education opportunities for physicians." A minimum of 150 credit hours of CME must be earned over a 3-year period to qualify for the Award. The hours may include such activities as conferences, residencies, teaching, writing, private reading, listening to cassettes, home study courses, consultation, and peer review; at least 60 of the hours, however, must be from formal CME programs sponsored or co-sponsored for Category I credit by organizations accredited for these activities.

The MAG House of Delegates has set a goal that all MAG members shall have received the PRA by 1985. We congratulate the following physicians who have distinguished themselves and their profession by their commitment to continuing education:

Young Whan Ahn, Marietta
Kenneth B. Alonso, Atlanta
Sergio C. Alvarez-Mena, Hardwick
Angel C. Alvarez, Columbus
John L. Anderson, Macon
Julia V. Ashley, Monroe
Garry L. August, Columbus
Charles R. Baisden, Augusta
Julia E. Ballard, Atlanta
Madhukar S. Bandisode, Augusta
Benjamin Bashinski, Augusta
John A. Bell, Dublin
Morton P. Berenson, Columbus
William G. Bissell, Augusta
Ronald C. Bloodworth, Smyrna
Joseph H. Boutwell, Decatur
David M. Boyette, Albany
Harry H. Brill, Columbus
Harold J. Brody, Atlanta
Mark Brown, Augusta
William O. Brown, Moultrie
Robert A. Burns, Augusta
James S. Cheatham, Smyrna
Yueh-Ying Cheng, Americus
Orlando Cabrera Cicero, Dublin
Isabella S. Collins, St. Simons Island
Ronald N. Cook, Atlanta
Gerald M. Cross, Hinesville
David B. Dennison, Atlanta
Arthur E. Diamond, Marietta
Albert V. Dixon, Albany
Pierce K. Dixon, Gainesville
William L. Dobes, Atlanta
Nancy L. Engel, Atlanta
Dennis L. Fielder, Atlanta
William R. Fisher, Atlanta
Evan L. Frederickson, Atlanta
Phillip C. Galle, Augusta
Alfredo G. Garcia, East Point
Pedro F. Garcia, Atlanta
Amnon Gimpel, Atlanta
John B. Griffin, Atlanta
L. Harvey Hamff, Atlanta
William D. Hammonds, Atlanta
Billy S. Hardman, Gainesville
Thomas G. Hill, Decatur
Vendie H. Hooks, Augusta
Jack Hudson, Augusta
P. R. Kalathoor, Vidalia
Ronald I. Kaplan, Marietta
James A. Kaufmann, Atlanta
Ellis B. Keener, Gainesville
Michael B. Kibble, Atlanta
Hyun H. Kim, Atlanta
Thomas L. Kirtley, Columbus
Gilbert J. Kloster, Atlanta
Somanath G. Kudchadker, Columbus
Richard A. Langford, Dublin
Manuel S. Larrauri, Milledgeville
Paul A. Lavietes, Atlanta
Lorenzo M. Lecumberri, Savannah
George W. Lucas, Atlanta
Arthuro R. Lumapas, Milledgeville
Paul T. Manchester, Atlanta
Samuel J. Miller, LaGrange
George E. Mixon, Augusta
Vincent Molinari, Smyrna
Enrique Montero, Griffin
Dearing A. Nash, Savannah
Robert W. Oliver, Dublin
Thomas W. Oliver, Tucker
Judy I. Orosz, Augusta
Jesus Ortiz, Savannah
Kantilal L. Patel, Dublin
Manharbhai N. Patel, Griffin
John A. Pennington, Marietta
Peter Phillips, Atlanta
David T. Plaxico, Macon
Charles E. Pollock, Washington
William C. Rhangos, Savannah
Thomas W. Rickner, Dublin
Sava M. Roberts, Augusta
James V. Robertson, Blairsville
Antonio R. Rodriguez, Columbus
Fernando Rodriguez, Lilburn
Randi V. Rosvoll, Atlanta
Arnold B. Rubenstein, Riverdale
Benjamin D. Saffan, Atlanta
Cora F. Salvino, Atlanta
Virendra M. Saxena, Fort Gaines
Lawrence B. Schlachter, Marietta
Walter H. Shehee, East Point
Young Shik Shin, Stockbridge
Ramesh K. Srivastava, Athens
Melody A. Stancil, LaGrange
Karen M. Starko, Atlanta
Jeff L. Stewart, Bowdon
David A. Stone, Hartwell
Joel D. Talley, Decatur
Paul Teplis, Atlanta
Chandrika B. Thakrar, Demorest
Diane L. Thiel, Tifton
Rex W. Tidwell, Macon
Jaydev R. Varma, Augusta
William R. Vogler, Atlanta
Don C. Walker, Newnan
George S. Walker, Eastman
James L. Wallingford, Ft. Benning
Marilyn D. Washburn, Avondale Estates
Jerry O. Weaver, Cedartown
Luiz Weksler, Macon
William Weston, Augusta
James H. Wheeler, Atlanta
Michael H. Whittle, Moultrie
Benjamin J. Wilds, Valdosta
Joseph S. Wilkes, Atlanta
Robert A. Williams, Dunwoody
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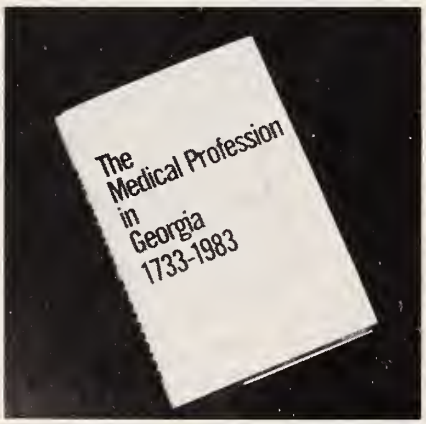
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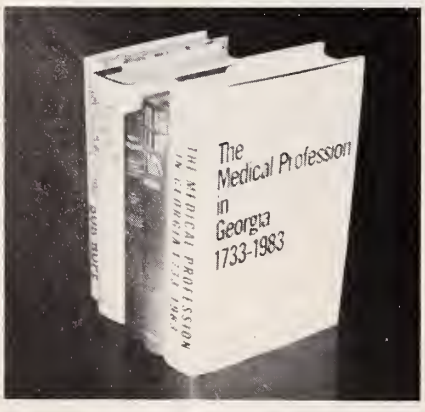
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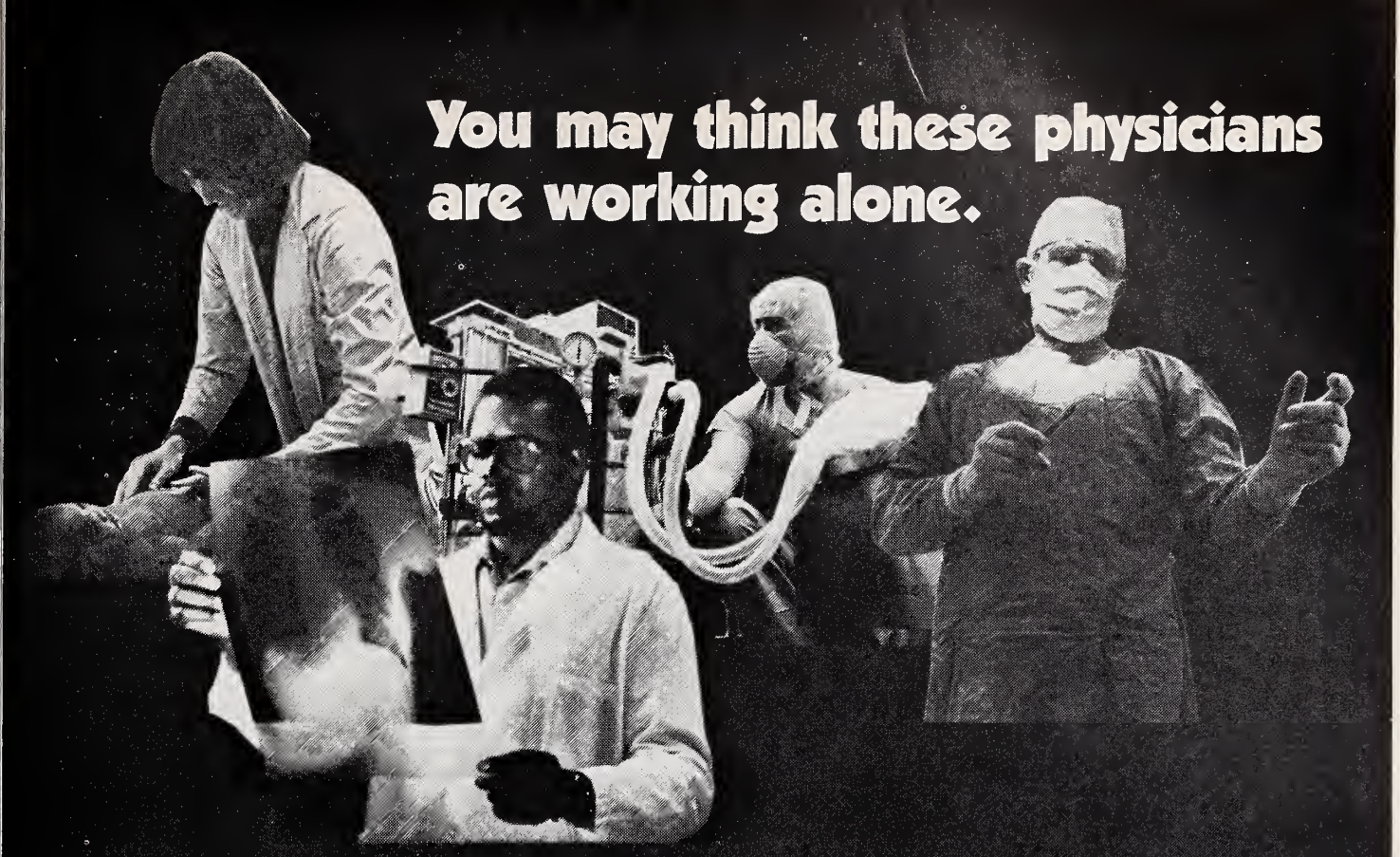
The Medical Profession in Georgia, 1733-1983 Now Available





The MAG Auxiliary's new book, *The Medical Profession in Georgia, 1733-1983*, is now ready for distribution. It may be ordered by sending a check for $25 (made payable to the Auxiliary to the Medical Association of Georgia) to the Auxiliary office at 938 Peachtree St., NE, Atlanta, Ga. 30309, or to Evelyn Ward Gay (Mrs. Brit B., Jr.), at 911 Vistavia Circle, Decatur, Ga. 30033.

Bound in red cloth with gold stamping, and covered with a glossy jacket in white with black lettering, the book will make an ideal gift for a friend (especially a medical student), a library (either a public, hospital, or school library), or to keep for yourself. Revenues from the sale of this 400-page volume will benefit the William R. Dancy, M.D. Student Loan Fund for Georgia medical students, a project sponsored by the MAG Auxiliary.



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JOURNAL
of the medical association of georgia
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MANUSCRIPTS — Articles are accepted for publication on the condition that they are contributed solely in this *Journal*. Manuscripts should be typewritten, double-spaced, and the original and one copy should be submitted. Receipt of manuscripts will be acknowledged and unused manuscripts returned. Used manuscripts will be returned only if requested.

STYLE — Ordinarily articles should not exceed 3,000 words. Only under exceptional circumstances will articles of over 4,000 words be published. Footnotes, bibliographies, and legends should be typed on separate sheets, double-spaced. Bibliographies should conform to the following style: name of author (with initials), title of article, name of periodical, date, volume (number, if available), and pages.

> Soter NA, Wasserman SI, Austen KF. Cold urticaria release into circulation of histamine and eosinophil chemotactic factor of anaphylaxis during cold challenge. N Engl J Med 1976;294:687-90.

NEWS NOTES — District and county medical societies, Association members, and readers are invited to send in any news items of general concern to members of the Medical Association of Georgia.

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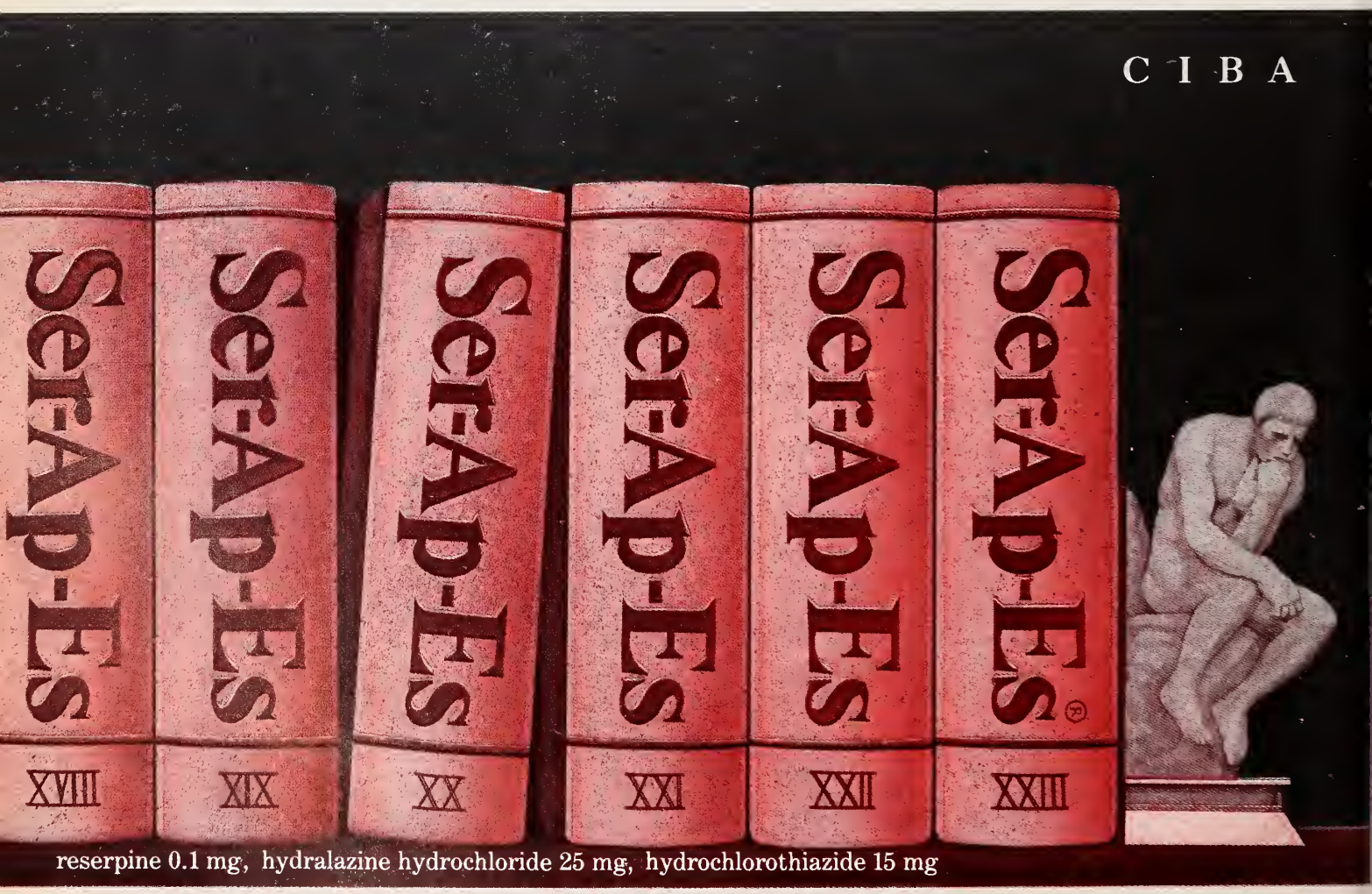
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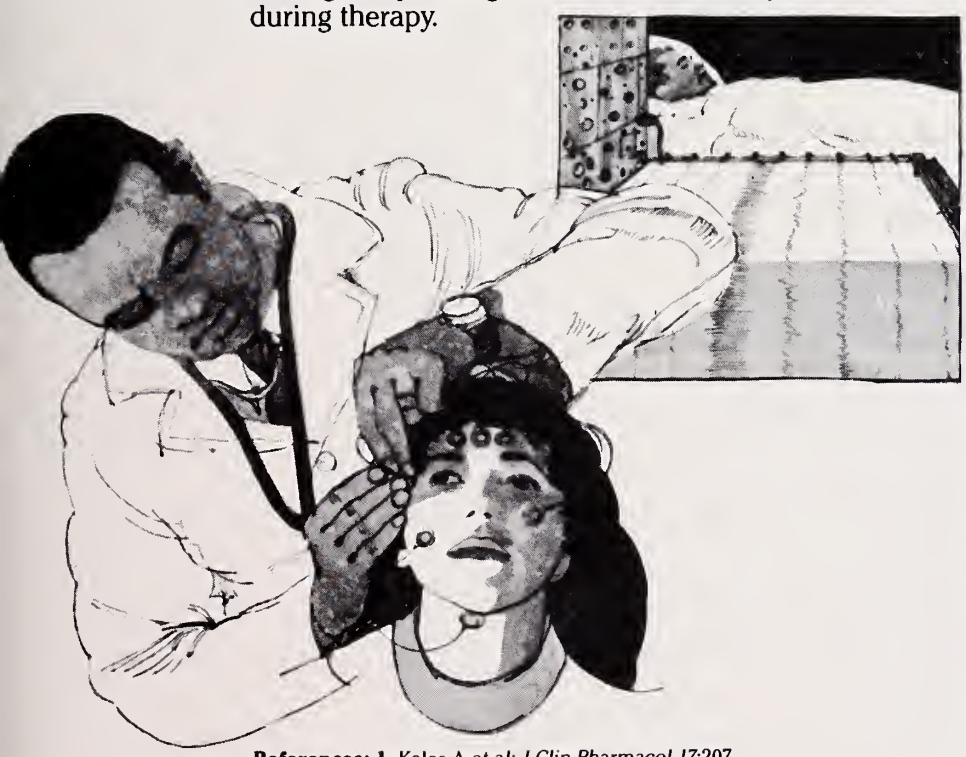
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References: 1. Kales A *et al: J Clin Pharmacol 17*:207-213, Apr 1977 and data on file, Hoffmann-La Roche Inc., Nutley, NJ. **2.** Kales A: Data on file, Hoffmann-La Roche Inc., Nutley, NJ. **3.** Zimmerman AM: *Curr Ther Res 13*:18-22, Jan 1971. **4.** Kales A *et al: JAMA 241*:1692-1695, Apr 20, 1979. **5.** Kales A, Scharf MB, Kales JD: *Science 201*:1039-1041, Sep 15, 1978. **6.** Kales A *et al: Clin Pharmacol Ther 19*:576-583, May 1976. **7.** Kales A, Kales JD: *Pharmacol Physicians 4*:1-6, Sep 1970. **8.** Frost JD Jr, DeLucchi MR: *J Am Geriatr Soc 27*:541-546, Dec 1979. **9.** Dement WC *et al: Behav Med 5*:25-31, Oct 1978. **10.** Vogel GW: Data on file, Hoffmann-La Roche Inc., Nutley, NJ. **11.** Karacan I, Williams RL, Smith JR: The sleep laboratory in the investigation of sleep and sleep disturbances. Scientific exhibit at the 124th annual meeting of the American Psychiatric Association, Washington, DC, May 3-7, 1971. **12.** Pollak CP, McGregor PA, Weitzman ED: The effects of flurazepam on daytime sleep after acute sleep-wake cycle reversal. Presented at the 15th annual meeting of the Association for Psychophysiological Study of Sleep, Edinburgh, Scotland, June 30-July 4, 1975. **13.** Data on file, Hoffmann-La Roche Inc., Nutley, NJ.

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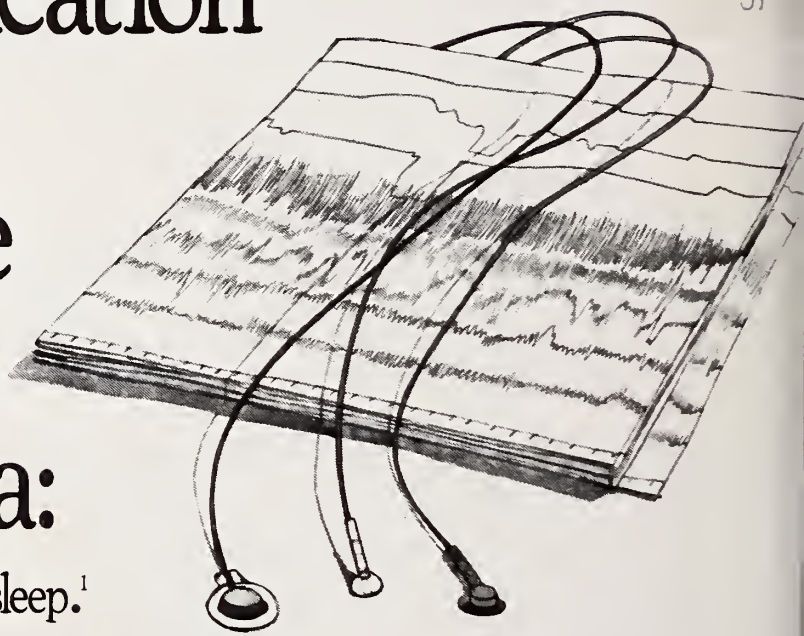
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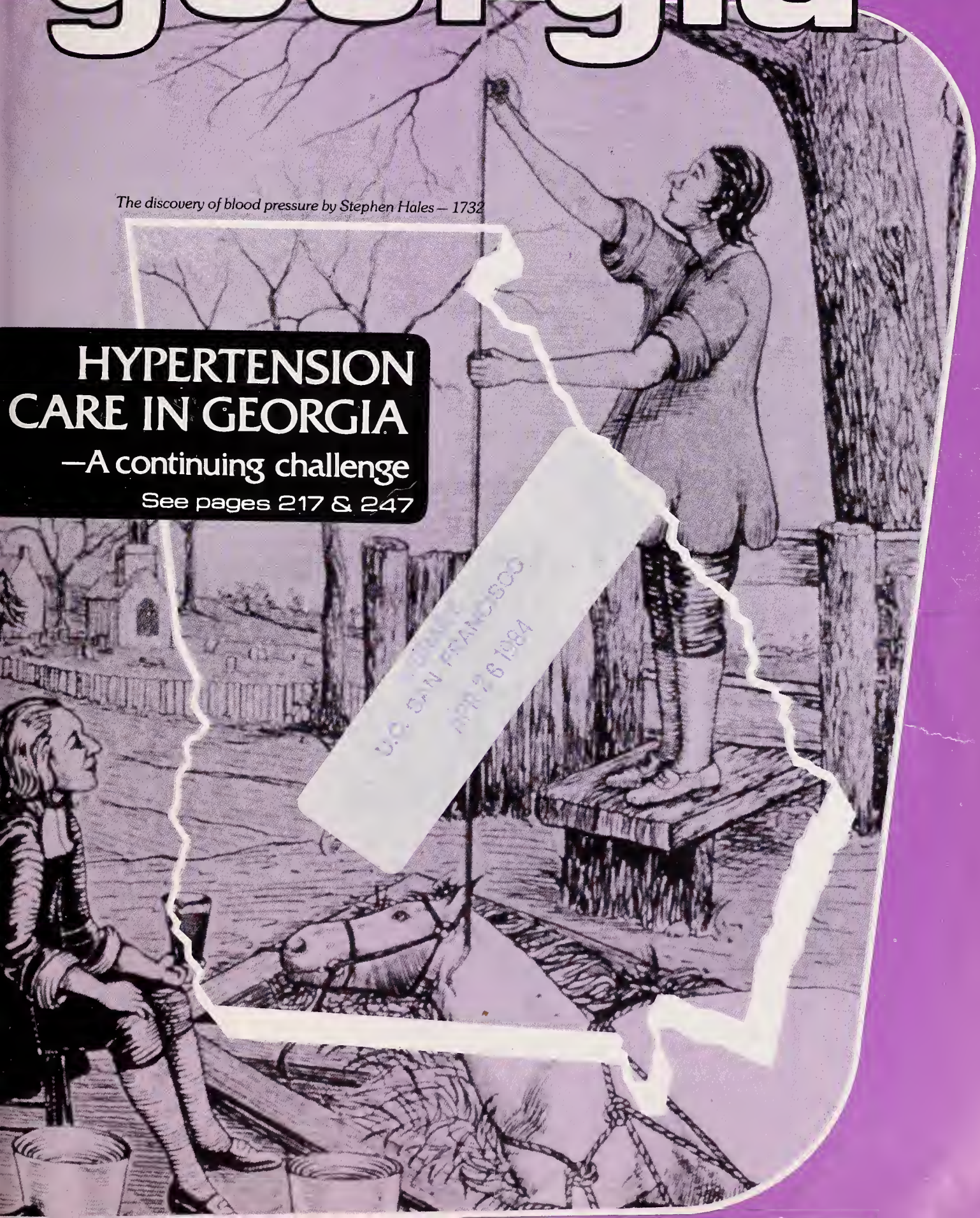
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HYPERTENSION CARE IN GEORGIA
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See pages 217 & 247

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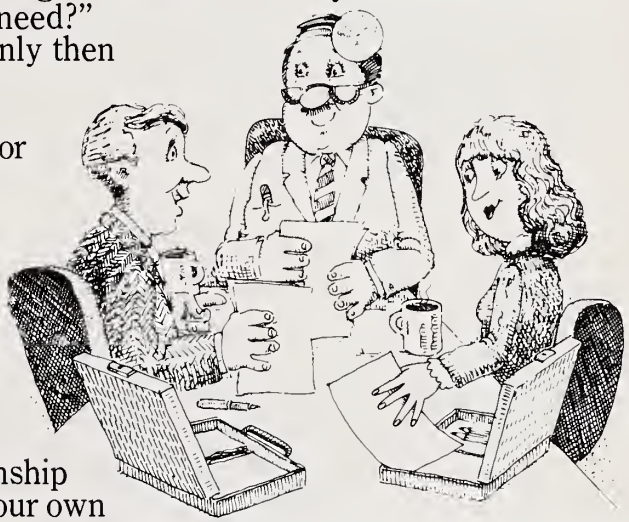
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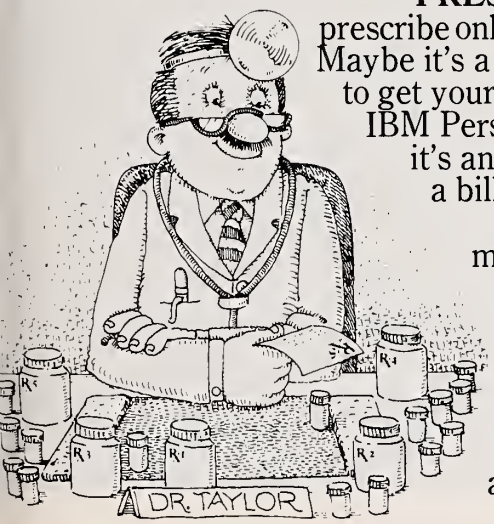
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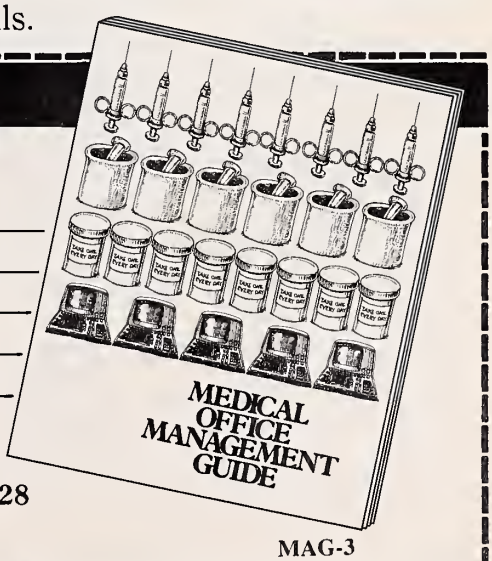
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The subscription price per year for members of the Medical Association of Georgia is $7.50, included in the annual membership dues. The subscription price for nonmembers is $15.00 in the United States, Canada and Mexico, and $17.00 in other countries. Single copies are $2.

The *Journal of the Medical Association of Georgia* is published monthly at 938 Peachtree Street, N. E., Atlanta, GA 30309-3990. Second-class postage paid at Atlanta, Georgia, and at additional mailing offices. POSTMASTER: Send address changes to Medical Association of Georgia, 938 Peachtree Street, N. E., Atlanta, GA 30309-3990.

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THE COVER

The featured article (p. 217) and editorial (p. 247) in this issue of the *Journal* discuss the results of a random sample of 1335 Georgia physicians surveyed in 1981 to determine the usual pattern of hypertension patient care. The study reveals the need for specific improvements in the optimal management of hypertensive patients.

This month's cover depicts the Reverend Stephen Hales' historic experiment in 1732 to determine the blood pressure of a horse. Cover design by Richard Lyons of Richard Heiman Advertising, Inc.

Letter to the Editor . . .

Another Perspective on Homosexuality

Dear Sir:

I read with considerable interest Dr. Alfred A. Messer's article "A Current Perspective on Homosexuality," published in the November, 1983, issue [of the *Journal*]. Dr. Messer's discussion of the problem of homosexuality, though published as an editorial, derives from his professional experience, not mere personal opinion or prejudice. His knowledge of this disorder is considerable and his treatment of it in this article balanced, tasteful, and thoughtful.

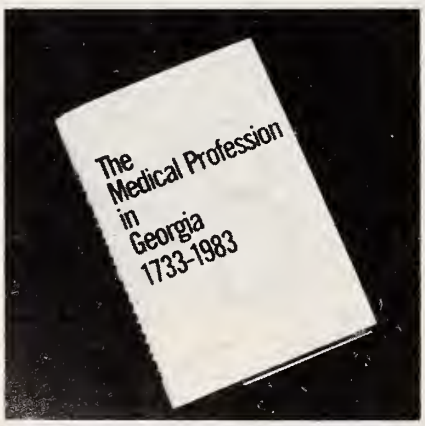
In subsequent issues of the *Journal,* three individuals have carped at his statements, claiming prejudice, inappropriateness, misuse of terms and error. These critical letters have come from a general practitioner, a psychiatrist (Dr. Edward O. Nix) and the project coordinator for AID Atlanta. These individuals clearly lobby for acceptance of homosexuality as an alternate lifestyle and appear to be allies of the homosexual community. Their comments should be understood in that context.

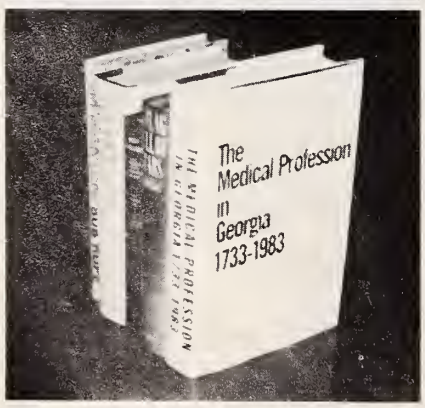
Dr. Nix's comment on the notorious APA vote to remove homosexuality as an illness suggests that the vote was a political maneuver. On that he and I might agree. Reality isn't changed by a vote. This vote, and not Dr. Alfred Messer, should be an embarrassment to the APA.

I am deeply pleased that the *Journal of the Medical Association of Georgia* publishes articles by competent medical professionals like Dr. Messer. I am equally pleased that you publish dissenting views, however partisan and ill-founded these might be.

Sincerely,
Stephen W. Edmondson, M.D.,
Psychiatrist, Atlanta

The Medical Profession in Georgia, 1733-1983 Now Available





The MAG Auxiliary's new book, *The Medical Profession in Georgia, 1733-1983*, is now ready for distribution. It may be ordered by sending a check for $25 (made payable to the Auxiliary to the Medical Association of Georgia) to the Auxiliary office at 938 Peachtree St., NE, Atlanta, Ga. 30309, or to Evelyn Ward Gay (Mrs. Brit B., Jr.), at 911 Vistavia Circle, Decatur, Ga. 30033.

Bound in red cloth with gold stamping, and covered with a glossy jacket in white with black lettering, the book will make an ideal gift for a friend (especially a medical student), a library (either a public, hospital, or school library), or to keep for yourself. Revenues from the sale of this 400-page volume will benefit the William R. Dancy, M.D. Student Loan Fund for Georgia medical students, a project sponsored by the MAG Auxiliary.

Incidental Intelligence . . .

Request for Physician Fee Freeze

On February 23, 1984, the American Medical Association's Board of Trustees unanimously authorized sending a letter to each physician in the United States, urging him or her to:

1. Freeze fees for a one-year period, beginning immediately; and
2. Continue to take into account the financial circumstances of each of his or her patients — especially the unemployed, the uninsured, and those under Medicare — and to accept reduced fees when warranted.

Traditionally the AMA, with support from physicians across the country, has been in the forefront of assuring that the profession will do its fair share in providing cost effective medical care. For example:

*The inaugural address of the AMA president six years ago also asked physicians to decrease the rate of increase in their overall charges.

*In 1978, the AMA endorsed a voluntary program to restrain the rate of increase in physicians' fees, a program that resulted in the physician services component of the Consumer Price Index (CPI) registering below the all-items index.

*The Association has continually asked physicians to reduce or waive fees for the unemployed and others who have lost public or private insurance benefits. In response many local medical societies have set up programs to serve the temporarily unemployed.

*Several state medical associations have recently asked their members to voluntarily freeze their fees.

Diet/Drug Studies Reduce Heart Attack Risk

Coronary heart disease can be prevented in men at high risk by lowering blood cholesterol levels through diet and drugs, according to a government study released in a January issue of the *Journal of the American Medical Association*. (See also the Heart Page in February, 1984, issue of the *Journal of the Medical Association of Georgia* on the treatment of hyperlipidemia.)

Men receiving the anti-cholesterol drug cholestyramine experienced a total of 155 fatal and non-fatal heart attacks compared to 187 attacks experienced by men receiving a placebo, an NIH study found. Investigators calculated that the drug produced a 24% reduction in fatal heart attacks and a 19% reduction in non-fatal heart attacks.

There were other indicators of reduced risk: persons receiving the drug experienced a 24% reduction in positive ECG, a 20% reduction in angina, and a 21% reduction in coronary bypass surgery, compared to persons receiving a placebo.

"These results have the potential to markedly reduce the large number of heart attack deaths presently experienced in this country," said C. Edward Davis, Ph.D., deputy director of the Lipid Research Clinic Program at the University of North Carolina in Chapel Hill. Coronary heart disease is responsible for more deaths in the U.S. than any other disease: one per minute, or more than half a million each year.

Of the 560,000 persons who die in the U.S. each year from heart attacks caused by atherosclerosis, an estimated 100,000 could be saved by the study's anti-cholesterol regimen, said Basil Rifkind, M.D., of the National Heart, Lung, and Blood Institute in Washington, D.C.

The study was large and complex: 3,806 participants visited 13 medical centers across the U.S., collectively making 193,000 clinic visits, generating over 1 million data forms, giving 341,000 blood samples, and undergoing 72,000 electrocardiograms.

Participants were men aged 35 to 59 who had blood cholesterol levels of at least 265 mg/dl, but no clinical evidence of disease. The group was divided evenly into two identical subsets: half received diet instructions (restricted to 400 mg of cholesterol per day) and a placebo while the other half received identical diet instructions and the drug cholestyramine. The study was double-blind. Each patient was followed at least seven years; a few were followed 10 years.

When both treatment groups were on diet only, there was an average 3.5% fall in total cholesterol and a 4.0% fall in LDL cholesterol for all persons. With initiation of drug therapy, differences in cholesterol levels between the two treatment groups became apparent during the first year and maintained that gap throughout the study. Differences in disease rates between the two groups became apparent by the third year and widened for the duration of the study.

It has long been accepted that high cholesterol levels are linked to elevated incidence of heart disease. However, it had never actually been proven that cholesterol reduction causes a parallel reduction of disease. This study shows that, as a rough rule of thumb, each 1% fall in cholesterol level is associated with a 2% reduction in the rate of heart attack.

The study's findings should be extended to women and younger men with high blood cholesterol levels, the researchers said. People with more modest cholesterol elevation could also benefit by cholesterol reduction, they say.

MEDICAL MEETING CALENDAR

APRIL

26-29—*Atlanta:* **MAG House of Delegates.** Contact J. Tom Sawyer, MAG, 938 Peachtree St., NE, Atlanta 30309. PH:404/876-7535 or 1-800-282-0224 (toll free in Ga).

26-29—*Atlanta:* **American College of Physicians.** Contact ACP, 4200 Pine St., Philadelphia, PA 19104. PH:215/243-1200.

27-28—*Augusta:* **Ocular Toxicology.** Category 1 credit. Contact Div. of Cont. Ed., MCG, Augusta 30912. PH:404/828-3967.

27-29—*Atlanta:* **Advanced Cardiovascular Diagnostic, Therapeutic, Rehabilitation, and Patient Follow-Up Methods.** AMA Category 1 and AAFP prescribed credits. Contact International Med. Educ. Corp., 64 Inverness Dr. E., Englewood, CO 80112. PH:800-525-8651.

30-May 3—*Callaway Gardens:* **Acute Injuries to the Knee.** Contact American Acad. of Orthopaedic Surgeons, 444 N. Michigan Ave., 15th Fl., Chicago, IL 60611.

30-May 5—*Augusta:* **19th Annual Family Practice Symposium.** AMA Category 1 and AAFP prescribed credit. Contact Div. of Cont. Educ., MCG, Augusta 30912. PH:404/828-3967.

MAY

3-4—*Atlanta:* **TUR.** Contact Merrily Laube, Southern Foundation for Edu. and Medical Research, Inc., 98 Currier St., Atlanta 30303. PH:404/688-3323.

3-6—*Sea Island:* **Georgia Society of Ophthalmology.** Category 1 credit. Contact Talitha Russell, Adm. Asst., 938 Peachtree St., NE, Atlanta 30309. PH:404/876-7535 or 1-800-282-0224 (toll free in Ga.).

10-11—*Columbus:* **Twelfth Annual Perinatal Medicine Conference.** Category 1 credit. Contact Div. of Perinatology, The Medical Center, P.O. Box 951, Columbus 31994. PH:404/324-4711.

10-12—*Macon:* **Conflicts with Newborns: Saving Lives, Scarce Resources, and Euthanasia.** Category 1 credit. Contact Prof. Richard McMillan, Mercer Univ. Sch. of Med., Rm E-61, Macon 31207. PH:912/744-4045.

10-13—*Jekyll Island:* **8th Annual Meeting of Anesthesia Associates: "New Concepts in Anesthesia and Monitoring."** Category 1 credit. Contact Nancy Cunningham, Pres., Am. Acad. of Anesth. Assoc., P.O. Box 15237, Atlanta 30333. PH:404/875-1735.

11-12—*Atlanta:* **3rd Annual Update of the Diagnosis and Treatment of Lupus Erythematosus.** Category 1 credit. Contact Stephen Balch, M.D., Dir., Jacquelyn McClure Lupus Treatment Ctr., 3200 Howell Mill Rd., NW, Atlanta 30324. PH:404/351-0351.

11-13—*Atlanta:* **Southeastern Regional Meeting—Christian Medical Foundation: "Changes in Medicine in the 1980s."** Category 1 credit. Contact Walker C. McGraw, M.D., McGraw Indus. Clinic, 6185 S. Buford Hwy., #C-112, Norcross 30071. PH:404/449-5161.

18—*Atlanta:* **Childhood Arthritis Update.** Category 1 credit. Contact Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., NE, Atlanta 30322. PH:404/329-5695.

18-20—*Augusta:* **Allergy and Immunology—Recent Advances.** Category 1 credit. Contact Div. of Cont. Ed., MCG, Augusta 30912.

30-June 2—*Hilton Head, SC:* **American Academy of Clinical Anesthesiologists Spring Seminar.** Category 1 credit. Contact Donald G. Catron, M.D., Program Director, AACA, P. O. Box 11691, Knoxville, TN 37939-1681. PH:615/588-6279.

31—*Valdosta:* **Cardiovascular Risk Factors in Children.** Category 1 credit. Contact Sandra Owen, Ga. Affil., American Heart Assn., Box 13589, Atlanta 30324. PH:404/261-2260.

JUNE

6-9—*Atlanta:* **Society for Vascular Surgery and International Society for Cardiovascular Surgery Joint Meeting.** Contact Univ. of Tex., Health Science Ctr., 5323 Harry Hines Blvd., Dallas, TX 75235.

7-9—*Atlanta:* **Clinical Topics in GYN-OB.** Category 1 credit. Contact Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., NE, Atlanta 30322. PH:404/329-5695.

11-14—*Kiawah Island, SC:* **Internal Medicine.** AMA Category 1 and AAFP prescribed credit. Contact Div. of Cont. Ed., MCG, Augusta 30912. PH:404/828-3967.

21-23—*Hilton Head, SC:* **Neurology.** AMA Category 1 and AAFP prescribed credits. Contact Div. of Cont. Ed., MCG, Augusta 30912. PH:404/828-3967.

JULY

12-14—*Kiawah Island, SC:* **Obstetrics.** AMA Category 1 and AAFP prescribed credit. Contact Div. of Cont. Ed., MCG, Augusta 30912. PH:404/828-3967.

13-15—*Sea Island:* **Providing Quality Medical Care in Your Practice.** Contact Southern Med. Assn., 2601 N. Highland Ave., Box 2446, Birmingham, AL.

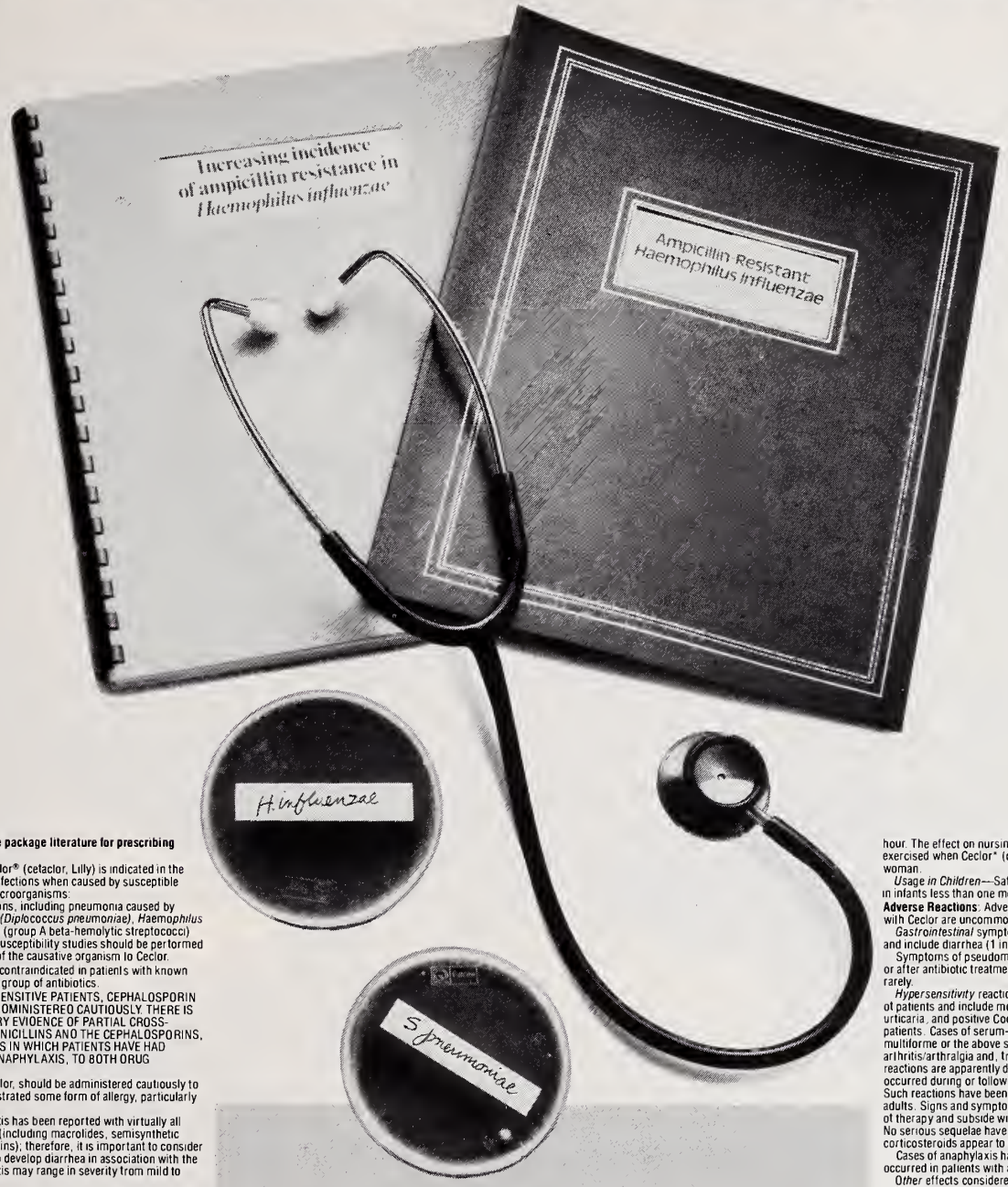
23-25—*Kiawah Island, SC:* **Pediatric Update—1984.** AMA Category 1 and AAFP prescribed credit. Contact Div. of Cont. Ed., MCG, Augusta 30912. PH:404/828-3967.

26-28—*Kiawah Island, SC:* **Clinical Genetics.** AMA Category 1 and AAFP prescribed credit. Contact Div. of Cont. Ed., MCG, Augusta 30912. PH:404/828-3967.

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Although we receive many notices for excellent continuing education meetings, all too often the information is received too late for timely inclusion in our Medical Meeting Calendar. In order for *your* meeting to be included, please send us the necessary information *two months* in advance of the issue in which you want it to appear. For example: for the August issue, copy is due by June 20; for the September issue, copy is due by July 20, etc. Mail to: Stephen Davis, Director of Education, MAG, 938 Peachtree St., NE, Atlanta, GA 30309.

An added complication... in the treatment of bacterial bronchitis*



Some ampicillin-resistant strains of Haemophilus influenzae—a recognized complication of bacterial bronchitis*—are sensitive to treatment with Ceclor.[1-6]

In clinical trials, patients with bacterial bronchitis due to susceptible strains of Streptococcus pneumoniae, H. influenzae, S. pyogenes (group A beta-hemolytic streptococci), or multiple organisms achieved a satisfactory clinical response with Ceclor.[7]

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cefaclor
Pulvules®, 250 and 500 mg

Brief Summary. Consult the package literature for prescribing information.

Indications and Usage: Ceclor® (cetaclor, Lilly) is indicated in the treatment of the following infections when caused by susceptible strains of the designated microorganisms:

Lower respiratory infections, including pneumonia caused by *Streptococcus pneumoniae (Diplococcus pneumoniae), Haemophilus influenzae*, and *S. pyogenes* (group A beta-hemolytic streptococci)

Appropriate culture and susceptibility studies should be performed to determine susceptibility of the causative organism to Ceclor.

Contraindication: Ceclor is contraindicated in patients with known allergy to the cephalosporin group of antibiotics.

Warnings: IN PENICILLIN-SENSITIVE PATIENTS, CEPHALOSPORIN ANTIBIOTICS SHOULD BE ADMINISTERED CAUTIOUSLY. THERE IS CLINICAL AND LABORATORY EVIDENCE OF PARTIAL CROSS-ALLERGENICITY OF THE PENICILLINS AND THE CEPHALOSPORINS, AND THERE ARE INSTANCES IN WHICH PATIENTS HAVE HAD REACTIONS, INCLUDING ANAPHYLAXIS, TO BOTH DRUG CLASSES.

Antibiotics, including Ceclor, should be administered cautiously to any patient who has demonstrated some form of allergy, particularly to drugs.

Pseudomembranous colitis has been reported with virtually all broad-spectrum antibiotics (including macrolides, semisynthetic penicillins, and cephalosporins); therefore, it is important to consider this diagnosis in patients who develop diarrhea in association with the use of antibiotics. Such colitis may range in severity from mild to life-threatening.

Treatment with broad-spectrum antibiotics alters the normal flora of the colon and may permit overgrowth of clostridia. Studies indicate that a toxin produced by *Clostridium difficile* is one primary cause of antibiotic-associated colitis.

Mild cases of pseudomembranous colitis usually respond to drug discontinuance alone. In moderate to severe cases, management should include sigmoidoscopy, appropriate bacteriologic studies, and fluid, electrolyte, and protein supplementation. When the colitis does not improve after the drug has been discontinued, or when it is severe, oral vancomycin is the drug of choice for antibiotic-associated pseudomembranous colitis produced by *C. difficile*. Other causes of colitis should be ruled out.

Precautions: *General Precautions*—If an allergic reaction to Ceclor occurs, the drug should be discontinued, and, if necessary, the patient should be treated with appropriate agents, e.g., pressor amines, antihistamines, or corticosteroids.

Prolonged use of Ceclor may result in the overgrowth of nonsusceptible organisms. Careful observation of the patient is essential. If superinfection occurs during therapy, appropriate measures should be taken.

Positive direct Coombs' tests have been reported during treatment with the cephalosporin antibiotics. In hematologic studies or in transfusion cross-matching procedures when antiglobulin tests are performed on the minor side or in Coombs' testing of newborns whose mothers have received cephalosporin antibiotics before parturition, it should be recognized that a positive Coombs' test may be due to the drug.

Ceclor should be administered with caution in the presence of markedly impaired renal function. Under such conditions, careful clinical observation and laboratory studies should be made because safe dosage may be lower than that usually recommended.

As a result of administration of Ceclor, a false-positive reaction for glucose in the urine may occur. This has been observed with Benedict's and Fehling's solutions and also with Clinitest® tablets but not with Tes-Tape® (Glucose Enzymatic Test Strip, USP, Lilly).

Broad-spectrum antibiotics should be prescribed with caution in individuals with a history of gastrointestinal disease, particularly colitis.

Usage in Pregnancy—Pregnancy Category B—Reproduction studies have been performed in mice and rats at doses up to 12 times the human dose and in ferrets given three times the maximum human dose and have revealed no evidence of impaired fertility or harm to the fetus due to Ceclor. There are, however, no adequate and well-controlled studies in pregnant women. Because animal reproduction studies are not always predictive of human response, this drug should be used during pregnancy only if clearly needed.

Nursing Mothers—Small amounts of Ceclor have been detected in mother's milk following administration of single 500-mg doses. Average levels were 0.18, 0.20, 0.21, and 0.16 mcg/ml at two, three, four, and five hours respectively. Trace amounts were detected at one hour. The effect on nursing infants is not known. Caution should be exercised when Ceclor* (cetaclor, Lilly) is administered to a nursing woman.

Usage in Children—Safety and effectiveness of this product for use in infants less than one month of age have not been established.

Adverse Reactions: Adverse effects considered related to therapy with Ceclor are uncommon and are listed below.

Gastrointestinal symptoms occur in about 2.5 percent of patients and include diarrhea (1 in 70).

Symptoms of pseudomembranous colitis may appear either during or after antibiotic treatment. Nausea and vomiting have been reported rarely.

Hypersensitivity reactions have been reported in about 1.5 percent of patients and include morbilliform eruptions (1 in 100). Pruritus, urticaria, and positive Coombs' tests each occur in less than 1 in 200 patients. Cases of serum-sickness-like reactions (erythema multiforme or the above skin manifestations accompanied by arthritis/arthralgia and, frequently, fever) have been reported. These reactions are apparently due to hypersensitivity and have usually occurred during or following a second course of therapy with Ceclor. Such reactions have been reported more frequently in children than in adults. Signs and symptoms usually occur a few days after initiation of therapy and subside within a few days after cessation of therapy. No serious sequelae have been reported. Antihistamines and corticosteroids appear to enhance resolution of the syndrome.

Cases of anaphylaxis have been reported, half of which have occurred in patients with a history of penicillin allergy.

Other effects considered related to therapy included eosinophilia (1 in 50 patients) and genital pruritus or vaginitis (less than 1 in 100 patients).

Causal Relationship Uncertain—Transitory abnormalities in clinical laboratory test results have been reported. Although they were of uncertain etiology, they are listed below to serve as alerting information for the physician.

Hepatic—Slight elevations of SGOT, SGPT, or alkaline phosphatase values (1 in 40).

Hematopoietic—Transient fluctuations in leukocyte count, predominantly lymphocytosis occurring in infants and young children (1 in 40).

Renal—Slight elevations in BUN or serum creatinine (less than 1 in 500) or abnormal urinalysis (less than 1 in 200).

[061782R]

* Many authorities attribute acute infectious exacerbation of chronic bronchitis to either *S. pneumoniae* or *H. influenzae*.

Note. Ceclor is contraindicated in patients with known allergy to the cephalosporins and should be given cautiously to penicillin-allergic patients.

Penicillin is the usual drug of choice in the treatment and prevention of streptococcal infections, including the prophylaxis of rheumatic fever. See prescribing information.

References

1. Antimicrob. Agents Chemother., *8*:91, 1975.
2. Antimicrob. Agents Chemother., *11*:470, 1977.
3. Antimicrob. Agents Chemother., *13*:584, 1978.
4. Antimicrob. Agents Chemother., *12*:490, 1977.
5. Current Chemotherapy (edited by W. Siegenthaler and R. Luthy), II:880. Washington, D.C.: American Society for Microbiology, 1978.
6. Antimicrob. Agents Chemother., *13*:861, 1978.
7. Data on file, Eli Lilly and Company.
8. Principles and Practice of Infectious Diseases (edited by G.L. Mandell, R.G. Douglas, Jr., and J.E. Bennett), p. 487. New York: John Wiley & Sons, 1979.

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Additional information available to the profession on request from Eli Lilly and Company, Indianapolis, Indiana 46285.

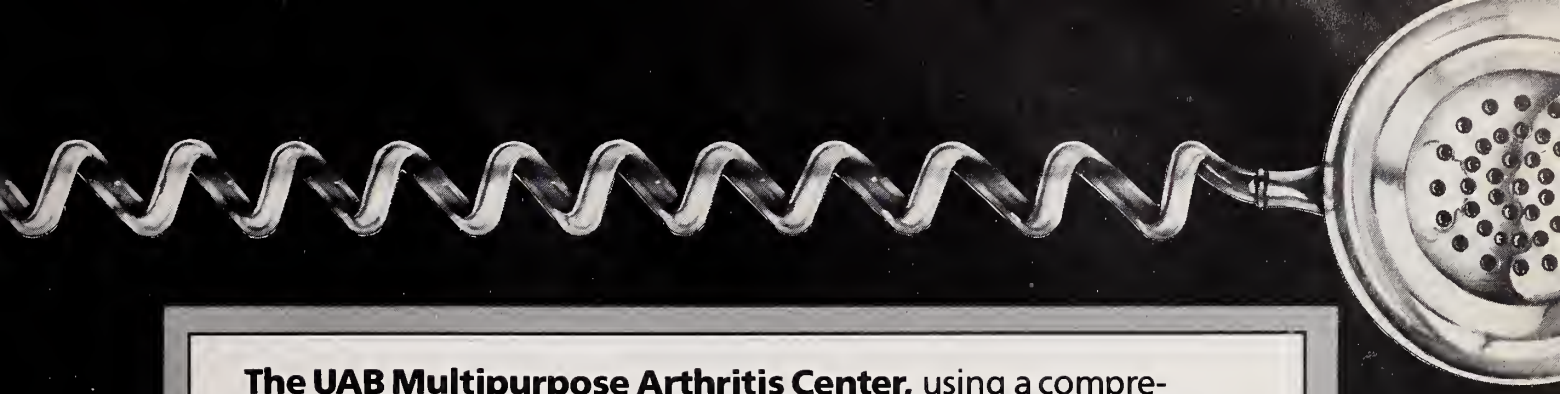
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The Center emphasizes a team approach involving rheumatologists, orthopedists, physical and occupational therapists, psychologists, social workers, pharmacists, nutritionists, specially trained nurses and patient educators.

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- **Clinical Trials of New Drugs Using Specific Protocols**

The following outpatient specialty clinics are also offered by the Center:

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- **Juvenile Arthritis (JA)**
- **Gold Clinic**

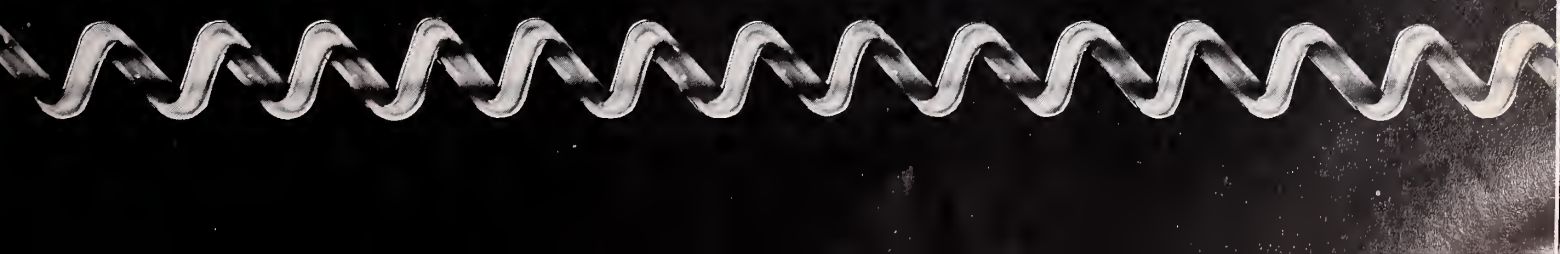
The Multipurpose Arthritis Center is one of 60 departments, divisions, and centers of the University of Alabama Medical Center accessible to you through this toll-free service.

The Center welcomes physician inquiries. To speak with a physician, to consult about a patient or to refer a patient, telephone by using the toll-free MIST number. This service, including the telephone call, is free.

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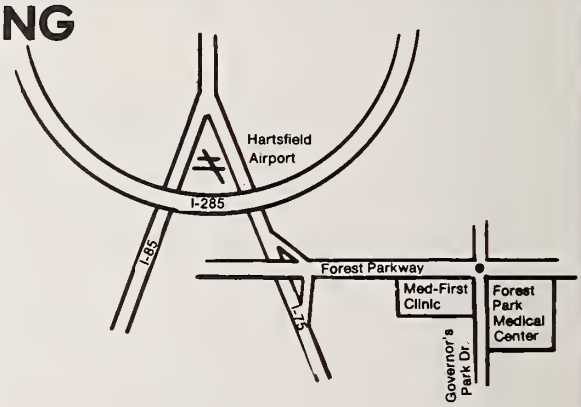


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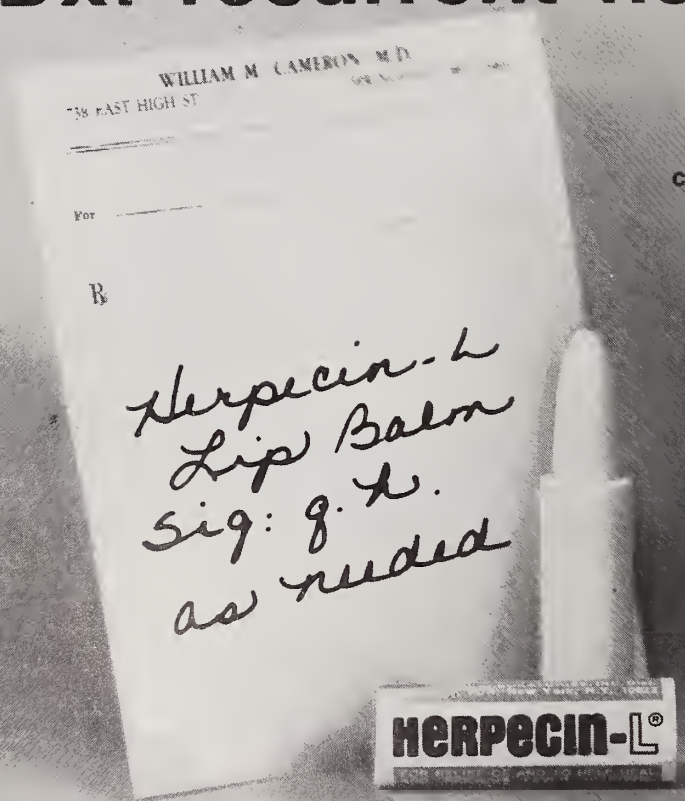
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e prescribing, see complete prescribing information in CO. literature or *PDR*. The following is a brief summary.

RNING

s drug is not indicated for initial therapy of edema or ertension. Edema or hypertension requires therapy ted to the individual. If this combination represents the age so determined, its use may be more convenient in ent management. Treatment of hypertension and edema ot static, but must be reevaluated as conditions in each ent warrant.

aindications: Concomitant use with other potassium- g agents such as spironolactone or amiloride. Further use ria, progressive renal or hepatic dysfunction, hyperkalemia isting elevated serum potassium. Hypersensitivity to either onent or other sulfonamide-derived drugs.

ngs: Do not use potassium supplements, dietary or other- unless hypokalemia develops or dietary intake of potas- is markedly impaired. If supplementary potassium is d, potassium tablets should not be used. Hyperkalemia ccur, and has been associated with cardiac irregularities. It re likely in the severely ill, with urine volume less than one ay, the elderly and diabetics with suspected or confirmed nsufficiency. Periodically, serum K^+ levels should be deter- . If hyperkalemia develops, substitute a thiazide alone, t K^+ intake. **Associated widened QRS complex or arrhyth- equires prompt additional therapy.** Thiazides cross the ntal barrier and appear in cord blood. Use in pregnancy es weighing anticipated benefits against possible hazards, ing fetal or neonatal jaundice, thrombocytopenia, other se reactions seen in adults. Thiazides appear and tri- ene may appear in breast milk. If their use is essential, the t should stop nursing. Adequate information on use in en is not available. Sensitivity reactions may occur in ts with or without a history of allergy or bronchial asthma. ble exacerbation or activation of systemic lupus erythe- us has been reported with thiazide diuretics.

utions: Do periodic serum electrolyte determinations (par- ly important in patients vomiting excessively or receiving teral fluids, and during concurrent use with amphotericin B rticosteroids or corticotropin [ACTH]). Periodic BUN and creatinine determinations should be made, especially in derly, diabetics or those with suspected or confirmed renal ciency. Cumulative effects of the drug may develop in ts with impaired renal function. Thiazides should be used aution in patients with impaired hepatic function. They can itate coma in patients with severe liver disease. Observe rly for possible blood dyscrasias, liver damage, other idio- atic reactions. Blood dyscrasias have been reported in ts receiving triamterene, and leukopenia, thrombocyto- agranulocytosis, and aplastic and hemolytic anemia have eported with thiazides. Thiazides may cause manifestation nt diabetes mellitus. The effects of oral anticoagulants may creased when used concurrently with hydrochlorothiazide; e adjustments may be necessary. Clinically insignificant tions in arterial responsiveness to norepinephrine have reported. Thiazides have also been shown to increase the zing effect of nondepolarizing muscle relaxants such as urarine. Triamterene is a weak folic acid antagonist. Do ic blood studies in cirrhotics with splenomegaly. Anti- ensive effects may be enhanced in post-sympathectomy ts. Use cautiously in surgical patients. Triamterene has found in renal stones in association with the other usual us components. Therefore, 'Dyazide' should be used with n in patients with histories of stone formation. A few occur- s of acute renal failure have been reported in patients on de' when treated with indomethacin. Therefore, caution is d in administering nonsteroidal anti-inflammatory agents Dyazide'. The following may occur: transient elevated BUN atinine or both, hyperglycemia and glycosuria (diabetic requirements may be altered), hyperuricemia and gout, s intoxication (in hypokalemia), decreasing alkali reserve ossible metabolic acidosis. 'Dyazide' interferes with fluores- measurement of quinidine. Hypokalemia is uncommon with de', but should it develop, corrective measures should be such as potassium supplementation or increased dietary of potassium-rich foods. Corrective measures should be ed cautiously and serum potassium levels determined. ntinue corrective measures and 'Dyazide' should labora- alues reveal elevated serum potassium. Chloride deficit ccur as well as dilutional hyponatremia. Concurrent use chlorpropamide may increase the risk of severe hypo- nia. Serum PBI levels may decrease without signs of thyroid bance. Calcium excretion is decreased by thiazides. de' should be withdrawn before conducting tests for para- d function.

des may add to or potentiate the action of other antihyper- e drugs.

ics reduce renal clearance of lithium and increase the risk um toxicity.

se Reactions: Muscle cramps, weakness, dizziness, head- dry mouth; anaphylaxis, rash, urticaria, photosensitivity, ra, other dermatological conditions; nausea and vomiting, ea, constipation, other gastrointestinal disturbances; pos- ypotension (may be aggravated by alcohol, barbiturates, rcotics). Necrotizing vasculitis, paresthesias, icterus, eatitis, xanthopsia and respiratory distress including pneu- s and pulmonary edema, transient blurred vision, sialade- nd vertigo have occurred with thiazides alone. Triamterene een found in renal stones in association with other usual us components. Rare incidents of acute interstitial nephritis been reported. Impotence has been reported in a few ts on 'Dyazide', although a causal relationship has not established.

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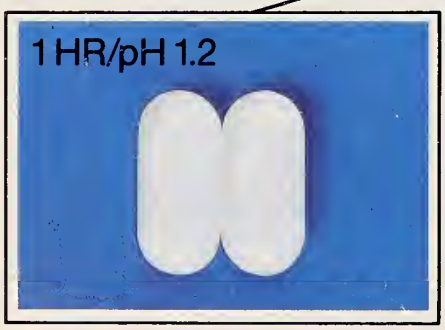
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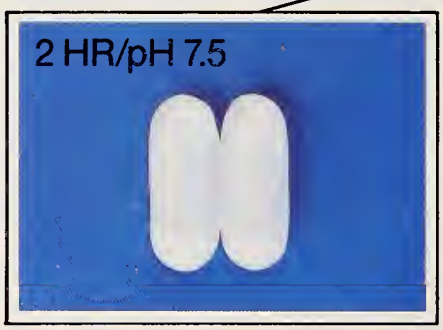
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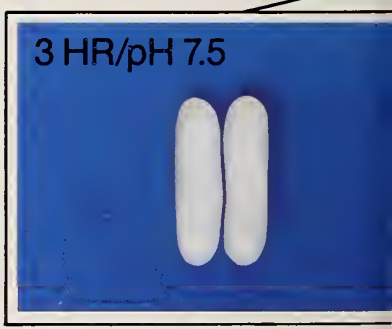
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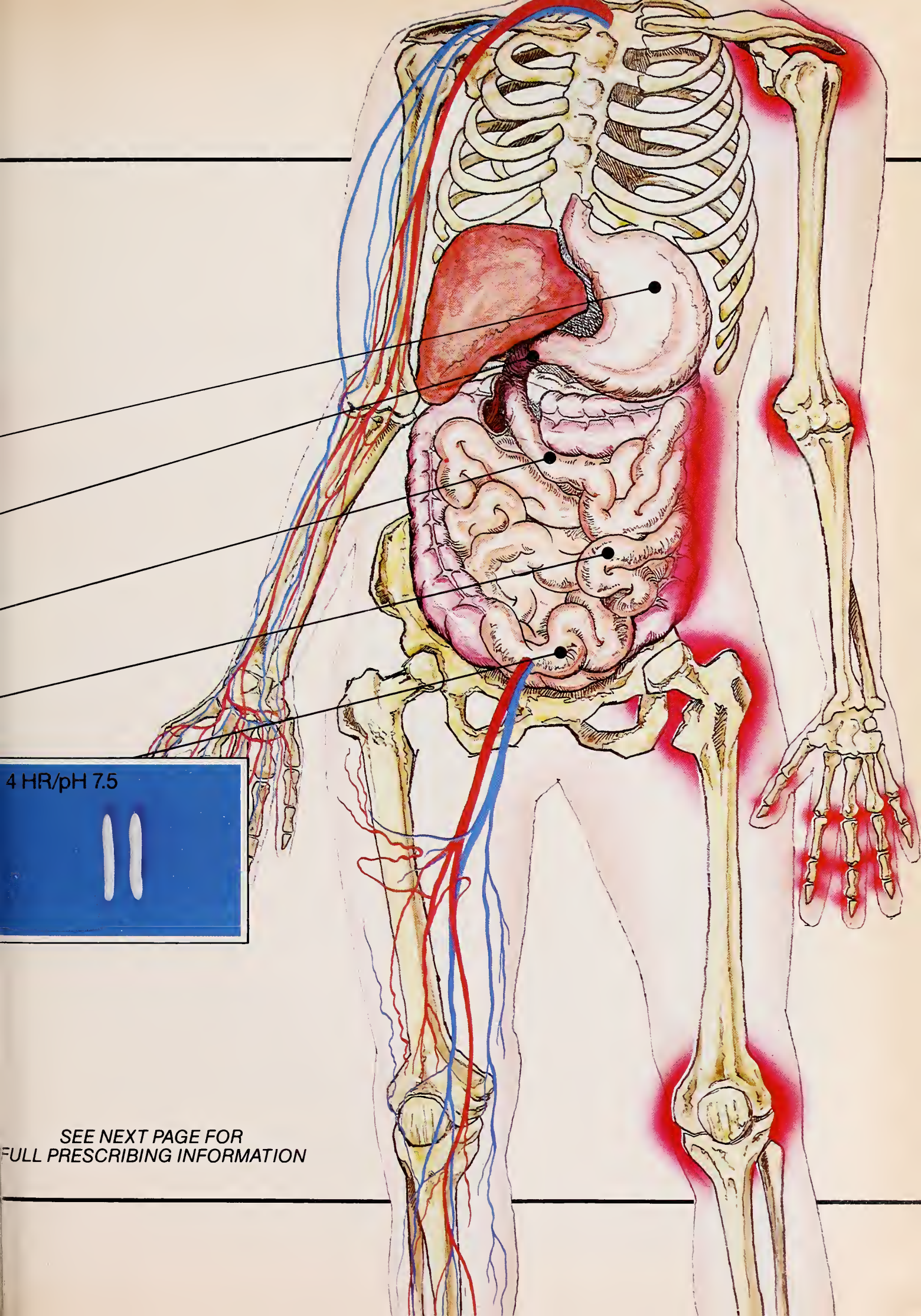


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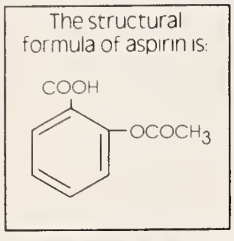
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FULL PRESCRIBING INFORMATION

ZORprin (ASPIRIN) Zero-Order Release

DESCRIPTION: Each capsule-shaped tablet of Zorprin contains 800 mg of aspirin, formulated in a special matrix to control the release of aspirin after ingestion. The controlled availability of aspirin provided by Zorprin approximates zero-order release; the *in vitro* release of aspirin from the tablet matrix is linear and independent of the concentration of the drug. □ **CLINICAL PHARMACOLOGY:** Aspirin, as contained in Zorprin, is a salicylate that has demonstrated anti-inflammatory and analgesic activity. Its mode of action as an anti-inflammatory and analgesic agent may be due to the inhibition of synthesis of prostaglandins, although its exact mode of action is not known. □ Zorprin dissolution is pH-dependent. *In vitro* studies have shown very little aspirin to be released in acidic solutions, whereas, Zorprin releases the majority of its aspirin (90%) in a zero-order mode at a neutral to alkaline pH. It is this pH dependence of Zorprin that reduces direct contact between aspirin and the gastric mucosa, resulting in a reduction of its gastrointestinal side-effect potential. □ Bioavailability data for Zorprin have confirmed that plasma levels of salicylic acid and acetylsalicylic acid can be measured 24 hours after a single oral dose. This substantiates a twice daily dose regimen. Multiple dose bioavailability studies showed similar steady-state salicylate levels for Zorprin as for conventional release aspirin using the same total daily dose. Long-term monitoring of salicylate levels showed no signs of accumulation once steady-state levels were reached (4-6 days). □ Studies of *in vivo* prostaglandin levels (PGE2) have shown Zorprin plasma levels of salicylic acid and acetylsalicylic acid to reduce PGE2 levels 14 hours after a single oral 800 mg dose while an equivalent dose of aspirin produced a reduction of PGE2 levels only through six hours. Zorprin's effect on prostaglandins other than PGE2 has not been determined. □ Salicylates are excreted mainly by the kidney, and from studies in humans it appears that salicylate is excreted in the urine as free salicylic acid (10%); salicyluric acid (75%) salicylic phenolic (10%); acyl glucuronides (5%) and gentisic acid (<1%). □ **INDICATIONS & USAGE:** Zorprin is indicated for the treatment of rheumatoid arthritis and osteoarthritis. The safety and efficacy of Zorprin have not been established in those rheumatoid arthritic patients who are designated by the American Rheumatism Association as Functional Class IV (incapacitated, largely or wholly bedridden, or confined to wheelchair, little or no self-care). □ In patients treated with Zorprin for rheumatoid arthritis and osteoarthritis, the anti-inflammatory action of Zorprin has been shown by reduction in pain, morning stiffness and disease activity as assessed by both the investigators and patients. □ In clinical studies in patients with rheumatoid arthritis and osteoarthritis, Zorprin has been shown to be comparable to conventional release aspirin in controlling the aforementioned signs and symptoms of disease activity and to be associated with a statistically significant reduction in the milder gastrointestinal side effects (see ADVERSE REACTIONS). Zorprin may be well tolerated in some patients who have had gastrointestinal side effects with conventional release aspirin, but these patients when treated with Zorprin should be carefully followed for signs and symptoms of gastrointestinal bleeding and ulceration. □ Since there have been no controlled trials to demonstrate whether or not there is any beneficial effect or harmful interaction with the use of Zorprin in conjunction with other nonsteroidal anti-inflammatory agents (NSAI), the combination cannot be recommended (see **Drug Interactions**). □ **Because of its relatively long onset of action, Zorprin is not recommended for antipyresis or for short-term analgesia.** □ **CONTRAINDICATIONS:** Zorprin should not be used in patients known to be hypersensitive to salicylates or in individuals with the syndrome of nasal polyps, angioedema, bronchospastic reactivity to aspirin, renal or hepatic insufficiency, hypoprothrombinemia or other bleeding disorders. Zorprin is not recommended for children under 12 years of age; it is contraindicated in all children with fever accompanied by dehydration. □ **WARNINGS:** Zorprin should be used with caution when anticoagulants are prescribed concurrently, since aspirin may depress platelet aggregation and increase bleeding time. Large doses of salicylates may have hypoglycemic action and enhance the effect of the oral hypoglycemics, concomitant use therefore is not recommended. However, if such use is necessary, dosage of the hypoglycemic agent must be reduced. The hypoglycemic action of the salicylates may also necessitate adjustment of the insulin requirements of diabetics. □ While salicylates in large doses have a uricosuric effect, smaller amounts may reduce water excretion and increase serum uric acid. □ USE IN PREGNANCY: Aspirin can harm the fetus when administered to pregnant women. Aspirin interferes with maternal and infant hemostasis and may lengthen the duration of pregnancy and parturition. Aspirin has produced teratogenic effects and increases the incidence of stillbirths and neonatal deaths in animals. □ If this drug is used during pregnancy, or if the patient becomes pregnant while taking this drug, the patient should be apprised of the potential hazard to the fetus. □ Aspirin should not be taken during the last 3 months of pregnancy. □ **PRECAUTIONS:** Appropriate precautions should be taken in prescribing Zorprin for patients who are known to be sensitive to aspirin or salicylates. Particular care should be used when prescribing this medication for patients with erosive gastritis, peptic ulcer, mild diabetes or gout. As with all salicylate drugs, caution should be exercised in prescribing Zorprin for those patients with bleeding tendencies or those on anticoagulants. □ In order to avoid exacerbation of disease or adrenal insufficiency, patients who have been on prolonged corticosteroid therapy should have their therapy tapered slowly rather than discontinued abruptly when Zorprin is made a part of the treatment program. □ Patients receiving large doses of aspirin and/or prolonged therapy may develop mild salicylate intoxication (salicylism) that may be reversed by dosage reduction. □ Salicylates can produce changes in thyroid function tests. □ Salicylates should be used with caution in patients with severe hepatic damage, preexisting hypoprothrombinemia, Vitamin K deficiency and in those undergoing surgery. □ Since aspirin release from Zorprin is pH dependent, it may change in those conditions where the gastric pH has been increased as a result of antacids, gastric secretion inhibitors or surgical procedures. □ **Drug Interactions:** (See **WARNINGS**) Aspirin may interfere with some anticoagulant and antidiabetic drugs. Drugs which lower serum uric acid by increasing uric acid excretion (uricosurics) may be antagonized by the concomitant use of aspirin, particularly in doses less than 2.0 grams/day. Nonsteroidal anti-inflammatory drugs may be competitively displaced from their albumin binding sites by aspirin. This effect may negate the clinical efficacy of both drugs. Also, the gastrointestinal inflammatory potential of nonsteroidal anti-inflammatory drugs may be potentiated by aspirin. The combination of alcohol and aspirin may increase the risk of gastrointestinal bleeding. □ Aspirin may enhance the activity of methotrexate and increase its toxicity. □ Sodium excretion produced by spironolactone may be decreased in the presence of salicylates. Concomitant administration of other anti-inflammatory drugs may increase the risk of gastrointestinal ulceration. Urinary alkalinizers decrease aspirin's effectiveness by increasing the rate of salicylate renal excretion. Phenobarbital decreases aspirin's effectiveness by enzyme induction. □ **Pregnancy Category D.** See **WARNINGS** Section. □ **Nursing Mothers:** Salicylates have been detected in the breast milk of nursing mothers. Because of the potential for serious adverse reactions from aspirin in nursing infants, a decision should be made whether to discontinue nursing or discontinue the drug, taking into account the benefit of the drug to the mother. □ **ADVERSE REACTIONS: Hematologic:** Aspirin interferes with hemostasis. Patients with a history of blood coagulation defects or receiving anti-coagulant drugs or with severe anemia should avoid Zorprin. Aspirin used chronically may cause a persistent iron deficiency anemia. □ **Gastrointestial:** Aspirin may potentiate peptic ulcer, and cause stomach distress or heartburn. Aspirin can cause an increase in occult bleeding and in some patients massive gastrointestinal bleeding. However, the greatest release of active drug from Zorprin is designed to occur in the small intestine over a period of time. This has resulted in fewer symptomatic gastrointestinal side effects. □ **Allergic:** Allergic and anaphylactic reactions have been noted when hypersensitive individuals have taken aspirin. Fatal anaphylactic shock, while not common, has been reported. □ **Respiratory:** Aspirin intolerance, manifested by exacerbations of bronchospasm and rhinitis, may occur in patients with a history of nasal polyps, asthma, or rhinitis. The mechanism of this intolerance is unknown but may be the result of aspirin-induced shunting of prostaglandin synthesis to the lipoxygenase pathway and the liberation of leukotrienes, e.g. slow-reacting substance of anaphylaxis. □ **Dermatologic:** Hives, rashes, and angioedema may occur, especially in patients suffering from chronic urticaria. □ **Central Nervous System:** Taken in overdoses, aspirin provides stimulation which may be manifested by tinnitus. Following initial stimulation, depression of the central nervous system may be noted. □ **Renal:** Aspirin rarely may aggravate chronic kidney disease. □ **Hepatic:** High doses of aspirin have been reported to produce reversible hepatic dysfunction. □ **OVERDOSAGE:** Overdosage, if it occurs, would produce the usual symptoms of salicylism: tinnitus, vertigo, headache, confusion, drowsines, sweating, hyperventilation, vomiting or diarrhea. Plasma salicylate levels in adults may range from 50 to 80 mg/dl in the mildly intoxicated patient to 110 to 160* mg/dl in the severely intoxicated patient. An arterial blood pH of 7.1 may indicate serious poisoning. The clearance of salicylates in children is much slower than adults and should receive due consideration when aspirin overdosages occur in infants; salicylate half-lives of 30 hours have been reported in infants 4-8 months old. Treatment for mild intoxication should include emptying the stomach with an emitic, or gastric lavage with 5% sodium bicarbonate. Individuals suffering from severe intoxication should, in addition, have forced diuresis by intravenous infusions of sodium bicarbonate and dextrose or sodium lactate. In extreme cases, hemodialysis or peritoneal dialysis may be required. □ (*A plasma salicylate level of 160 mg/dl in an adult is usually considered lethal.) □ **DOSAGE & ADMINISTRATION:** *In order to achieve a zero-order release, the tablets of Zorprin should be swallowed intact. □ Breaking the tablets or disrupting the structure will alter the release profile of the drug. □ It is recommended that Zorprin be taken with sufficient quantities of fluids (8 oz. or more).* □ **Adult Dosage:** For mild to moderate pain associated with rheumatoid arthritis and osteoarthritis, the recommended initial dose of Zorprin is 1600 mg (2-800 mg tablets) twice a day. Because of Zorprin's prolonged release of aspirin into the bloodstream, Zorprin tablets may be taken as a b.i.d. dose. Further adjustment of the dosage should be determined by the physician, based upon the patient's response and needs. Since it will take 4-6 days to reach steady-state levels of salicylic acid with Zorprin, it is recommended dosages be given for at least one week before further adjustment. In general, patients with rheumatoid arthritis seem to require higher doses of Zorprin than do patients with osteoarthritis. □ **Zorprin is not recommended for children below the age of 12.** □ **HOW SUPPLIED: Zorprin Tablets 800 mg;** plain, white capsule-shaped tablets. □ Bottles of 100 Tablets—NDC 0524-0057-01. □ **Caution:** Federal law prohibits dispensing without prescription. □ U.S. Patent No. 4,308,251. □ **Manufactured and Distributed by: BOOTS PHARMACEUTICALS, INC., Shreveport, Louisiana 71106 U.S.A.**



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Physician Hypertension Practice in Georgia — Results of the 1981 American Heart Association/Georgia Affiliate Physician Survey

WILLIAM M. McCLELLAN, M.D., *LaGrange,* JOSEPH A. WILBER, M.D., and W. DALLAS HALL, M.D., *Atlanta**

Abstract

A random sample of 1,335 Georgia physicians was surveyed in 1981 to determine the usual pattern of hypertensive patient care. A response rate of 63% compared favorably with the 1977 nationwide survey conducted by the Food and Drug Administration.

Adherence to treatment guidelines was reported for appropriate detection and screening in 74% of physicians, for proper diagnostic criteria (66%), for recommended drug therapeutic thresholds (83-91%), for selection of initial drug therapy (86%) and for recommended follow-up intervals (88-100%). Only 56%, however, used recommended interventional methods for follow-up of missed appointments.

The results suggest that optimal management of hypertensive patients could be further improved if blood pressure were measured routinely at every patient encounter, if serial measurements on separate occasions were used prior to establishing a diagnosis of hypertension, and if all practicing physicians would use some type of system to maintain active surveillance of patients who have missed their usual follow-up appointment.

* Dr. McClellan is Clinical Assistant Professor of Medicine, Dr. Wilber is Clinical Associate Professor of Medicine, and Dr. Hall is Professor of Medicine, Emory University School of Medicine, Atlanta, GA. Send reprint requests to Dr. McClellan at 303 Smith St., LaGrange, GA 30240.

PHYSICIAN-SELECTED treatment and management strategies are important determinants of whether hypertensive patients achieve long-term control of blood pressure. We have recently completed a survey to determine the current patterns of hypertension management among physicians practicing in a Southern state. This paper provides a summary of the survey results that are of primary interest for enhancement of care and control of blood pressure in the patient with hypertension.

Methods

A random sample was taken from all physicians listed in 1980 by the Georgia State Board of Medical Licensure as practicing general practice, family practice, internal medicine, pediatrics, or cardiology. Physician addresses were stratified as either metropolitan (living in a standard metropolitan statistical area [SMSA]), or non-metropolitan (Non-SMSA) according to the 1970 census. Half of each practice group in each strata (every other name alphabetically) was selected for the survey. In July-August, 1981, each physician selected was sent an introductory letter, followed by a survey that included questions about demographic characteristics, type of practice, and patterns of hypertension care. Preliminary field-testing indicated approximately 20 minutes were needed to complete the questionnaire. At 2 week intervals after the first mailing, non-responders were mailed a second and/or third copy of the survey. Non-responders to the third mailing

TABLE 1 — Standards Used for Evaluation of Hypertension Care as Reflected by the Survey*

Detection/Screening: **Appropriate detection was defined as a blood pressure measurement on all adult patients at each physician contact.**

Diagnostic Criteria: **Appropriate diagnosis of sustained hypertension was defined as two or more measurements with diastolic blood pressures >90 mmHg on two or more separate encounters.**

Therapeutic Threshold: **A sustained diastolic blood pressure between 90-104 mmHg was defined as the lowest acceptable range of blood pressure for initiation of drug therapy in adults.**

Initial Drug Selection: **Appropriate initial therapy was defined to be either a thiazide diuretic (alone or in combination) or a beta blocker.**

Frequency of Follow-up: **Follow-up frequency was defined to be appropriate if the patient was seen monthly or more often during the initiation of therapy. For well controlled hypertensives, the follow-up frequency was defined as appropriate if the patient was seen at least once every 6 months.**

Missed Follow-up Appointments: **Appropriate management of missed follow-up appointments was defined to be the use of a postcard, phone call, or other direct patient contact reminders.**

* An Appendix is attached, listing the key survey questions most relevant to each of the standards.

TABLE 2 — Questionnaire Completion Rate by Strata* of Physicians Sampled

Category	*Mailed*	*Completed*	*%*
Internal Medicine	424	251	59.2
Metropolitan	352	206	58.5
Non-metropolitan	72	45	62.5
Family Practice	291	172	59.1
Metropolitan	152	87	57.2
Non-metropolitan	139	85	61.2
General Practice	318	157	49.3
Metropolitan	158	81	51.3
Non-metropolitan	160	76	47.5
Cardiology	108	69	63.9
Metropolitan	95	64	67.4
Non-metropolitan	13	5	38.5
Pediatrics	194	130	67.0
Metropolitan	149	98	65.8
Non-metropolitan	45	32	71.1
TOTAL ALL GROUPS	1335	779	58.3
Metropolitan	906	536	59.2
Non-metropolitan	429	243	56.6

* Self-designated practice categories and stratification categories differ somewhat.

were contacted once by phone and asked to return the questionnaire.

Standards of hypertension care were based on the 1980 Joint Commission Statement on the Detection, Evaluation, and Treatment of High Blood Pressure and recent articles published in the *Journal of the Medical Association of Georgia*.[1-3] These standards are listed in Table 1.

Results

Surveys were mailed to 1,335 physicians. The unadjusted completion rate was 58.3% (Table 2). Surveys sent to retired (22), out-of-state (17) deceased (12), or incarcerated (2) physicians were deleted, as were duplicated surveys (3) and those returned because of incorrect or no forwarding address (22). The adjusted completion rate, after removal of the above categories, was 63%. Response rates varied from a high of 71.1% among non-metropolitan pediatricians, to a low of 38.5% among non-metropolitan cardiologists. As a group, pediatricians had the highest response rate (67%), while general practitioners had the lowest (49.3%). A declining response rate was obtained with each additional contact, ranging from 40% for the initial mailout to 1.8% for those ultimately contacted by phone.

The mean age of respondents was 46.1 years. Two-thirds had metropolitan addresses and one-third non-metropolitan. Self-designated practice categories included internists (28%), family practitioners (23.1%), general practitioners (14.7%), pediatricians (15.1%), cardiologists (8%), and other designations (10.5%). Practice organizations included solo practice (47.2%), partnerships (16.3%), small groups of 3-10 physicians (13.4%), large groups of greater than 10 physicians (2.8%), hospital-based practices (9.8%), neighborhood health centers or clinics (1.3%), HMOs (0.5%), and other practice arrangements (8.6%). Physicians in our survey saw an average of 24.6 patients a day. The average proportion of their patients with hypertension was reported to be 17.6%.

Blood pressure measurement on each routine contact with the physician's office was reported by approximately 75% of physicians.

Table 3 is a summary of the adherence to the standards for hypertension care as related to the management patterns reported by the physicians completing our survey in 1981. Blood pressure measurement on each routine contact with the physician's office was reported by approximately 75% of physicians; whereas 13.7% reported blood pressure measurement only at periodic examinations, or when there were appropriate symptoms (0.4%), other criteria for blood pressure measurement were reported by 12.1%. For the diagnosis of hypertension, serial blood pressure measurements at two or more visits were made by 66.4% of respondents. A diagnosis of hypertension was made from a single measurement of blood pressure at two separate visits by 17.6% of physicians and from blood pressure determinations on a single visit by 16%.

There were considerable differences in the levels of sustained diastolic hypertension felt to warrant drug intervention (i.e., the therapeutic threshold).

TABLE 3 — Physicians Reporting Appropriate Hypertension Practice (1981)

Practice		*% Adhering to Standard Care*
Detection/Screening		73.7
Diagnostic Criteria		66.4
Therapeutic Threshold	Age 20-29	83.1
	Age 30-49	90.8
	Age 50-69	89.6
Initial Drug Selection		86.1
Frequency of Follow-up		
New Patient	Mild	88.0
	Moderate	97.0
	Severe	99.9
Controlled Patient	Mild	94.4
	Moderate	99.5
	Severe	100.0
Missed Appointment Reminder		55.7

TABLE 4 — Therapeutic Threshold for Instituting Drug Therapy, According to Ranges for Diastolic Blood Pressure and Age of the Patient

Diastolic BP (mmHg)	*Age 20-29*	*Age 30-49*	*Age 50-69*
80-84	2.0%	0.5%	1.2%
85-89	14.3%	7.0%	4.6%
90-94	56.6%	51.2%	32.8%
95-99	19.7%	28.8%	34.3%
100-104	6.8%	10.8%	22.5%
105-109	0.5%	1.4%	3.2%
110-114	—	0.2%	1.2%
115-119	—	—	0.1%

Table 4 illustrates the threshold where physicians generally institute therapy, classified by the level of diastolic pressure and the age group of the patient. For example, in the youngest patient age group (20-29), 83.1% of physicians felt that drug therapy was indicated when diastolic blood pressure was confirmed in the range 90-104 mmHg, while only 0.5% felt that a diastolic blood pressure should be greater than 104 mmHg to begin drug therapy. One-sixth of physicians (16.3%) indicated they would begin drug treatment for age 20-29 patients with diastolic blood pressures between 80-89 mmHg. In the two older patient age groups, approximately 90% of responding physicians would initiate drug therapy for a diastolic blood pressure between 90-104 mmHg, and less than 10% would begin drug therapy for levels below 90 mmHg.

A broad range of step-one drugs was selected for initial therapy (Table 5). Thiazide (or thiazide-like) diuretics, alone (63.4%) or in combination with reserpine (4.5%) or a beta-blocker (5.5%) were selected by 73.5% of responding physicians. Potassium-sparing diuretics were selected by 10.6%, and mild sedatives or tranquilizers were used initially by 4.2%. Initial therapy with only a beta-blocker was reported by 1.6%.

TABLE 5 — Drugs Selected to Initiate Therapy in Moderate Hypertension (Diastolic BP 110-120 in a 50-year-old male)

Drug	*% Using*
Thiazide diuretic only	63.4
Potassium-sparing diuretic	10.6
Thiazide diuretic plus beta-blocker	5.5
Thiazide diuretic plus reserpine	4.5
Mild sedative/tranquilizer	4.2
Beta-blocker only	1.6
Methyldopa	1.1
Furosemide	1.0
Clonidine	0.6
Thiazide plus reserpine	0.5
Prazosin	0.5
Hydralazine	0.3
Reserpine	0.2

Follow-up during initial therapy of new patients was monthly or more often for mild hypertensives (87.9% of respondents), every 2 weeks or less for moderate hypertensives (83%), and weekly for severe hypertensives (87.5%). Once control was established, the frequency of follow-up was semiannually or more often for mild hypertensives (95%), and quarterly or more often for moderate and severe hypertensives (91-98%).

Missed follow-up patient appointments led to intervention by only 56% of physicians. The method of follow-up included phone calls (51%) and postcards (4.9%). Physicians in non-SMSA practice locations were less likely than SMSA physicians to use any follow-up method.

Discussion

Our survey response rate of 63% compares quite favorably to that reported by the 1977 Nationwide Survey of Physicians Knowledge, Attitudes, and Reported Behavior in the Diagnosis and Management of Hypertension (i.e., 45% for questionnaire mailings and an additional 21% from personal interviews) and many other telephone and mail surveys concerning physician knowledge and practice patterns.[4-8] Our results could be biased because they represent only the opinions of those who responded; however, the Nationwide Survey did not find significant differences between attitudes held by responders and nonresponders contacted for personal interviews. Moreover, self-reporting may either overestimate or underestimate actual practice. However, since our responders represent a third of all physicians in our state likely to be caring for hypertensive patients, the results can be taken as a reasonable estimate of the boundaries of actual practice and therefore demand our attention.

Standards of care for hypertension have been formulated a number of times and disseminated during the last decade.[1, 9, 10] The degree to which

physicians adhere to such standards, however, is variable.[11] Langfeld surveyed patients hospitalized for nonhypertensive causes and found high levels of physician nontreatment and discontinuation of therapy among hypertensive patients.[12] Alderman and Ochs[13] reported unsatisfactory blood pressure control (among hypertensives managed in a university center medical clinic) associated with inadequate adherence to standards of care and follow-up by clinic physicians. Similar observations have been made in an internal medicine private practice where chart audit revealed frequent nontreatment of labeled hypertensive patients, high nonadherence of follow-up criteria, and unacceptable attainment of goal blood pressure.[14] These outcomes were attributed to reliance on "conventional regimens" for hypertensive care rather than the use of more recent management strategies.

This survey found considerable variation in the reported hypertension practices of physicians, further supporting the supposition that such practices might not be uniformly adequate and may contribute to inadequate control of high blood pressure in the population.

In a 1971 survey of admissions to a university, a community and two Veterans Administration Hospitals, Frohlich et al.[15] found that blood pressures were not recorded by 10% of the admitting physicians. In another multi-hospital survey, comparison of hypertension screening results to hospital outpatient clinic records showed that many hypertensive patients had not had their blood pressure recorded during multiple clinic visits.[16]

These earlier studies raised considerable concern regarding the adequacy of care of the hypertensive patient. This concern has been reinforced by epidemiologic studies that continue to reveal diminishing but unacceptable numbers of undetected, untreated, and uncontrolled hypertensives in the community.[17]

These observations, however, were not always representative of physicians practicing in the community; in addition, many of these studies were conducted during the period that preceded programs to improve physician awareness of accepted hypertension treatment. The 1977 Food and Drug Administration (FDA) nationwide survey was designed to compare physician attitudes with the then recently published First Joint National Committee Recommendations on Detection, Evaluation, and Treatment of High Blood Pressure.[10] This survey found considerable variation in the reported hypertension practices of physicians, further supporting the supposition that such practices might not be uniformly adequate and may contribute to inadequate control of high blood pressure in the population. The variation from existing standards of care found in this survey, however, included both failures to achieve minimum performance of some standards of care as well as a more aggressive attitude toward treatment than was warranted by current consensus recommendations. The observation that physicians might be overtreating as well as undertreating hypertension was also made by Thompson et al.[18] in a survey of institutional hypertension care in New York. These investigators found that respondents to their survey were treating diastolic blood pressures lower than could be justified by existing consensus recommendations.

There were considerable differences in the levels of sustained diastolic hypertension felt to warrant drug intervention.

Our current survey was conducted approximately 1 year following publication of the updated recommendations of the Joint National Committee.[1] It includes questions used by the FDA survey, plus additional questions regarding follow-up of patients who had missed appointments. It provides an indication of how hypertension practice patterns may have changed during the 4-year interval between the surveys and further emphasizes the problems of under- and over-treatment of hypertension.

The first hypertension-related service provided by a physician is the routine measurement of blood pressure on all patients, regardless of the reason for the patient contact. Although we found fairly high levels of adherence for this standard of hypertension practice, much improvement could be made. For example, only 73.7% of reporting physicians measured blood pressure at every patient visit, as compared to 79% of the physicians in the 1977 FDA survey. Physicians measuring blood pressure only as part of a periodic physical examination (13.7%) or when there are symptoms of elevated blood pressure (0.4%) need to further consider the episodic nature of much primary care and the asymptomatic character of mild hypertension. Sackett has emphasized the importance of screening at all patient-physician encounters as the most practical means of screening for hypertension.[19]

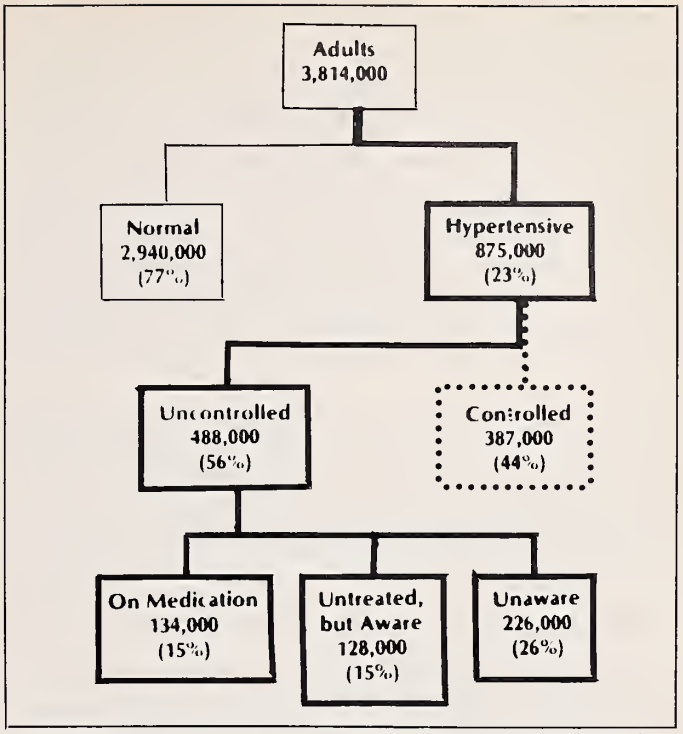
The need for serial measurements of blood pressure prior to making a diagnosis of hypertension is well established. It reflects the tendency of isolated blood pressure elevation to normalize, a phenomenon known as regression toward the mean. The Joint National Commission recommendations are

that, after screening, mild and moderate elevations of blood pressure be confirmed at two separate visits.[1] Use of multiple measurements on at least two separate visits will eliminate most of the variation.[20] Multiple measurements prior to a diagnosis of sustained hypertension were reported by 73% of the 1977 FDA survey group and only 66% in our sample of physicians. A single blood pressure measurement was selected by 4.1%, and multiple measurements at a single visit by 12.0% of our sample. This is similar to the pattern found in the FDA survey. Nonadherence to this standard by 34% of our sample is of concern because of the likelihood that normotensives may be misdiagnosed as hypertensive and placed on chronic drug therapy with the concomitant costs and risks. In the HDFP Study, approximately half of the individuals with average diastolic blood pressures between 95-104 mmHg at home screening had a normal blood pressure (DBPs 90 mmHg) on rescreening.[17] Without serial blood pressure measurements, many of these individuals might have been labeled and treated as established hypertensives.

A failure to screen for hypertension at each patient contact and to follow up hypertensive nonattenders suggests that many hypertensives remain needlessly undetected and untreated.

In our survey, many physicians indicated that drug therapy was used for treatment of diastolic blood pressures of less than 90 mmHg (e.g., 16.3% of physicians indicated they would treat at a diastolic blood pressure of 80-89 mmHg at age 20-29, 7.5% at age 30-49, and 5.8% at age 50-69). In the FDA survey, 7% of responding physicians also indicated that they would treat patients 20-30 years of age with diastolic blood pressure 85-89 mmHg or lower, and 1% selected this treatment threshold for each of the other two age categories.[4] While there is considerable controversy about the appropriate treatment of mild hypertension (DBP 90-104 mmHg), there is no support whatsoever (at this time) for drug treatment of repeated diastolic blood pressures in the 80-89 range[21-23] The reason for this increasing drug-prescribing tendency for diastolic blood pressure <90 mmHg is unclear.

The grey zone of mild hypertension represents the group of patients in which one is most likely to find initially elevated blood pressure measurements that subsequently normalize with multiple readings over time. Thus, the tendency noted among many of our respondents not to use multiple blood pressure measurements prior to diagnosing sustained diastolic hypertension compounds the problems inherent in



Hypertension Incidence and Treatment in Georgia, 1981 — Data from Statewide Household Survey by the Georgia Department of Human Resources.

the use of low therapeutic thresholds and raises the possibility that normotensive individuals may be labeled hypertensive and needlessly treated.

The most recent (1980) published Joint National Committee standard for initial drug therapy is that, when not contraindicated, a thiazide diuretic be used (i.e., step one).[1] Nearly 85% of responding physicians indicated that they selected a diuretic to begin treatment, although only 63.4% chose a thiazide diuretic alone. Potassium-sparing diuretics were chosen by 10.6%, although they are, in general, more expensive than generic thiazides and may have less antihypertensive efficacy unless combined with a thiazide. In the FDA Study, 59% of physicians chose a thiazide diuretic alone, while another 28% chose a thiazide diuretic in combination with another drug. This 87% use of thiazides as step one therapy in 1977 is comparable to the 85% reported by physicians in our survey in 1981.

Once therapy is initiated, close supervision is necessary to ensure patient compliance and to monitor attainment of blood pressure control.[24] Georgia physicians generally choose appropriate follow-up intervals for both initiation and maintenance of therapy. One area not examined by the FDA Study was the pattern for follow-up of missed patient appointments; yet a major problem in long-term follow-up of hypertensive patients is visit nonadherence. For example, a 50% annual patient dropout rate was reported in one series.[25]

A variety of interventions to diminish therapeutic dropouts have been described. One of the more effective methods is the mailed missed appointment

reminder.[26-29] Only 55% of responding physicians used any missed appointment reminder and of these, fewer than 10% used mailed reminders. This failure to use missed appointment reminders is of concern because of the current observations that many uncontrolled hypertensives are now aware of their problem but have missed a follow-up appointment and lost contact with their physician for long periods.[30] Improved practice in this area may have great impact on blood pressure control in the community.

The results (of this survey) can be taken as a reasonable estimate of the boundaries of actual practice and therefore demand our attention.

In summary, physicians in our 1981 survey reported appropriate practice in detection and screening of hypertension (74%), diagnostic criteria (66%), therapeutic thresholds (83-90%), drug selection (86%), and follow-up frequency (88-100%). However, only 55% reported use of appropriate follow-up interventions for missed visits. The pattern of hypertension practice we found is one of both over- and under-treatment of the hypertensive patient. The failure to use multiple blood pressure measurements to diagnose hypertension and the tendency to prescribe drug therapy for diastolic blood pressures below 90 mmHg raise the possibility that normotensive individuals may be labeled and treated as hypertensive. On the contrary, a failure to screen for hypertension at each patient contact and to follow up hypertensive nonattenders suggests that many hypertensives remain needlessly undetected and untreated.

In view of the adverse consequences of both undiagnosed and misdiagnosed hypertension, improvement in both screening practices and diagnostic standards is important. The following four areas deserve either continued or new emphasis in any current adult high blood pressure treatment recommendations and/or programs designed for physician education:

(1) Measure blood pressure at each patient encounter, not just annual examinations or when there are symptoms.
(2) Obtain serial measurements (in most otherwise uncomplicated patients with mild or moderately elevated initial readings) on at least two separate occasions before either labeling a patient as hypertensive or before instituting drug therapy.
(3) Be aware that there is no currently established benefit of treating diastolic blood pressures below 90 mmHg at any age, and that the appropriate management of confirmed mild hypertension remains controversial.
(4) Use some type of missed appointment system, preferably one that includes scheduling and recording appointments prior to leaving the office, and one that contains an active surveillance system to identify and track patients with missed appointments.

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Appendix

Questions Used to Describe Patterns of Practice

Detection

Which procedure do you use for detection of hypertension in your patients?

1. Blood pressure of adult patient taken on every contact with physician's office.
2. Blood pressure of adult patient taken as part of periodic physical examination, but not necessarily on every contact with physician's office.
3. Blood pressure of adult patient taken only when patient has symptoms that could relate to high blood pressure.
4. Other.

Diagnosis

Which of the following procedures most nearly describes the usual procedure that you use in diagnosing mild or moderate hypertension?

1. Single blood pressure determination.
2. Two or more blood pressure determinations during same visit.
3. Single blood pressure determination during each of two or more visits.
4. Two or more blood pressure determinations during each of two or more visits.

Therapy Threshold

Please indicate the *lowest repeated diastolic blood pressure* at which you feel some kind of *drug therapy* is definitely in order to reduce the risk of cardiovascular and/or renal complications, even in the case of asymptomatic patients, for adults. Circle an answer for each of the three age ranges in the columns shown below.

Adult Age 20-29	*Adult Age 30-49*	*Adult Age 50-70*
Diastolic mmHg	Diastolic mmHg	Diastolic mmHg

Selections:

(1)	80-84	(5) 100-104
(2)	85-89	(6) 105-109
(3)	90-94	(7) 110-114
(4)	95-99	(8) 115-119

Drug Selection

Suppose that you have a 50-year-old patient with a diastolic pressure in the range of 100-120, and that you have decided on drug therapy. Please circle the code numbers below to show the procedure you would use if no specific drug interactions or contraindications are present.

Selections:

(1) Mild sedatives/tranquilizers
(2) Thiazide diuretics
(3) Potassium-sparing diuretics
(4) Furosemide (Lasix)
(5) Reserpine
(6) Thiazide-reserpine combination
(7) Methyldopa (Aldomet)
(8) Hydralazine (Apresoline)
(9) Guanethidine (Ismelin)
(10) Propranolol (Inderal)
(11) Clonidine (Catapres)
(12) Prazosin (Minipress)
(13) Minoxidil

Instruction: Use drug classification code from above; if applicable, circle codes for more than one.

Frequency of Follow-up

What is your recommended frequency of return office visits for hypertensive patients *while their blood pressure is being brought under control?* Use your own definition for mild, moderate, and severe hypertension. Categories were mild high blood pressure, moderate high blood pressure, and severe high blood pressure.

Selections:
a. weekly
b. twice per month
c. monthly
d. quarterly
e. semiannually
f. yearly
g. other

What is your recommended frequency of return visits for stabilized hypertensive patients? Same categories and selections as preceding question.

Missed Follow-up Appointments

When follow-up appointments for high blood pressure are missed, do you provide follow-up by:

Selections:
phone calls
postcards
home visit
no follow-up provided
other

Questions were derived in part from the Nationwide Survey of Physicians Knowledge, Attitudes, and Reported Behavior.

A self-contained (15-20 minute slide-tape) program "Follow-up of the Aware Hypertensive" is available on loan for hospital staff meetings from the American Heart Association, Georgia Affiliate. Contact Susan Hill, (404) 261-2260.

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The author believes that there is more cost saving available in control of utilization than in the actual cost of such utilization.

Utilization — The Name of the Game

LOUIS H. FELDER, M.D., *Atlanta**

One hears today of many forces from many quarters bearing on the practice of medicine and health care costs. One hears phrases such as contract medicine, alternate delivery systems, HMOs, PPOs, EPOs, hospital chains, benefits' managers, PROs, PSROs, DRGs, etc. In the momentary attention of an otherwise very busy mind, one hardly has time to contemplate how all these entities may relate to each other. One can certainly make a case for saying that a great deal of these various influences have to do with *utilization of medical services,* who determines how much, when, and what is the cost. One might consider the situation in the 1930s when health care services were paid for by the recipient of the services, and the recipient alone made the decision as to whether or not to go to a "provider"; if so, to which provider; and then whether or not to follow his advice. He knew, or could find out, approximately what this was going to cost, that he himself would be responsible for paying that bill, and, at each step of the way, could determine whether he wanted to take the next step or not. The decisions were based on the recipient's degree of sophistication, and the ramifications of seeking medical care services were fairly predictable.

Today, health care costs are 10.6% of the Gross National Product. This is 360 billion dollars a year, or nearly a billion dollars a day. Nearly 90% of the population of the United States is covered by health care insurance, the vast majority of which is furnished by either the government or an employer, usually a corporation. Both of these entities have made it clear that they feel that health care costs have gone about as high as they should go. It is appropriate then to review: How did health care costs get to be where they are, and what is to prevent them from rising even more? As noted in the beginning of this article, the answer to these questions lies largely in *utilization,* who determines it, and what it costs.

Today, the patient is the recipient of a great deal more medical information than 50 years ago, although a great deal of this is fragmentary and out of context. At any rate, being 90% indemnified, the recipient (patient) goes happily off to obtain a medical care service. The provider, typically a solo practicing primary care physician, then takes over with the permission of the patient a great many of the utilization decisions. Some of these decisions may then get delegated by mutual consent to a secondary provider or perhaps an institutional provider. Each of the latter two may make additional utilization considerations for ancillary services that they feel indicated, and again the patient evinces little economic concern. The major factors that go into the providers' considerations then are: (1) concern for optimally achievable medical care; (2) an advanced degree of technology available to accomplish that; (3) income for the provider; and (4) defensive medicine. The patient gets well, and the providers send the bills to a carrier, and, ultimately, a benefit's manager. Today, the latter two are demanding to get involved in the utilization decisions *as they are being made!*

It might be well to add to the background at this point by saying that approximately 40% of the total health care costs billed in the United States today is due to in-patient services in an acute care hospital. Approximately 20% is due to physicians' charges and the remaining 40% due to nursing homes, drugs

* Dr. Felder practices internal medicine. Send reprint requests to him at 35 Collier Rd., NW, Atlanta, Georgia 30309.

and ancillary out-patient services, such as, physiotherapy, respiratory therapy, home health care, etc. Accordingly, it is a very significant decision on the part of the initial physician to admit his patient to an acute care hospital, and this is where the thrust of attempts to control health care costs has been directed initially. It is the opinion of the writer that there is more cost saving available in control of utilization than in the actual cost of such utilization. The bottom line is that there is more meat in controlling the frequency and duration of hospitalization initiated by a physician than there is in approaching the cost of the physician and, to some extent, even the hospital, *for* that utilization. Partly for this reason, what we are now seeing are parties demanding to be involved in decisions regarding what a patient does or doesn't need *while these decisions are being made,* at least to the extent of attesting to what such parties will or won't pay for. In years past, this was unthinkable.

Alternate Delivery Systems

What are some of these parties and where do they intervene? The following describe some of the variations on the theme of alternate delivery systems, which is a euphemism for utilization regulation by entities other than the patient or his physician.

An HMO is an organization that agrees to indemnify a patient against most of his health care costs and assumes the responsibility for that for a set annual premium. The *closed panel HMO* hires physicians to render those health care services, but pays him the same whether they are rendered as an in-patient or an out-patient. The HMO also has veto authority over the physician's decision to hospitalize a patient. It may even, by contracting with a hospital or by owning its own hospital, have some measure of control over the cost of in-patient services.

IPA-type HMOs get the physicians to collectively agree to try to exercise enough restraint of their utilization practices to allow a finite number of dollars to reimburse them for their services and to take the risk that they will furnish the services even if the dollars run out before the duration of the contract runs out. In other words, in an IPA-type of HMO, the physicians are in a sense betting on the appropriateness and cost-effectiveness of their other IPA colleagues. There is a certain "withhold" from their agreed upon fees, early in the contract year, to make sure that the money will last the year out. The IPA-type HMO again exercises some authority and veto power over the necessity for hospitalization.

In a PPO, Preferred Provider Organization (which might be better termed a *Participating* Provider Organization), there is a guaranteed discount by both individual and institutional providers (physicians and hospitals).

All of these organizations have their own intrinsic peer review mechanisms which may include preadmission certification, concurrent review, and discharge planning.

In the case of the federal government, the PSROs (soon to be reorganized and redirected as PROs) apply initially retrospective but currently prospective pressures on utilization.

The mere existence and surveillance activities of peer review organizations, private and governmental, will do more to control the frequency and extent of utilization than any actual utilization opposition they may advance.

It is the opinion of the writer that the mere existence and surveillance activities of these peer review organizations, private and governmental, will do more to control the frequency and extent of utilization than any actual utilization opposition they may advance. As more public attention is called to the utilization problem by carriers, employers, the government, medical associations, and health care cost containment coalitions, it will serve to dampen the enthusiasm of the physician provider for any utilization that is not absolutely necessary.

All these alternate delivery systems, HMOs, PPOs, EPOs, Preferred or Participating Physicians Organizations, etc., are concerned with varying degrees of utilization control, cost control, quality control, financial risk sharing, and profit motivation. If one is presented with still another alternate delivery system for evaluation, one might list these five factors and then properly ask, to what degree does this particular plan involve itself with each of those factors?

It should be apparent from the above that all these pressures have the net effect of largely separating the recipient of all this utilization, namely, the patient, from the decision making process. This is not *all* bad because certainly the physician should know more about what the patient might justifiably invoke for his own good than the patient himself. However, in the case of those agencies or entities that are economically motivated in the field of utilization, this is not necessarily true.

It would seem that peer review is an activity that could hardly be questioned as to its having considerable merit. That it should be done by *otherwise* unencumbered true peers, rather than administrations motivated primarily by economic considerations, should also be apparent. (The perceptive physician will realize, however, that this increased peer review may constitute a mechanism for policing one's own profession — which has been a problem

and a stumbling block for many decades). It would seem, therefore, that any mechanism that could perpetuate the free enterprise, fee-for-service, private practice of medicine with appropriate peer review would be preferable to a great array of diverse influences "coming from various quarters" bearing on the situation. To the extent that efforts in this direction on a relatively voluntary "business as usual" basis have *not* prevented the increasing penetration of the "market" by closed-panel HMOs, for-profit chains, "emergicenters," etc., it is apparent that attempts to salvage the "practice freedom" alluded to above are going to demand drastic and perhaps somewhat repugnant changes. These may include: 1. organization (with some loss of autonomy); 2. publicity; 3. marketing; and, 4. "toothy" peer review, to include, (a) pre-admission certification (b) concurrent review, and (c) discharge planning, etc.

In the "Pre-Federal Trade Commission days of medical ethics," the medical profession was struggling hard to be what the public needed it to be, what it knew it should be, what it wanted to be. It is going to be more difficult now that we are in the age of the medical entrepreneur but, increasingly for that reason, more necessary. The individual physician needs to approach the future with an open mind and a willingness to change.

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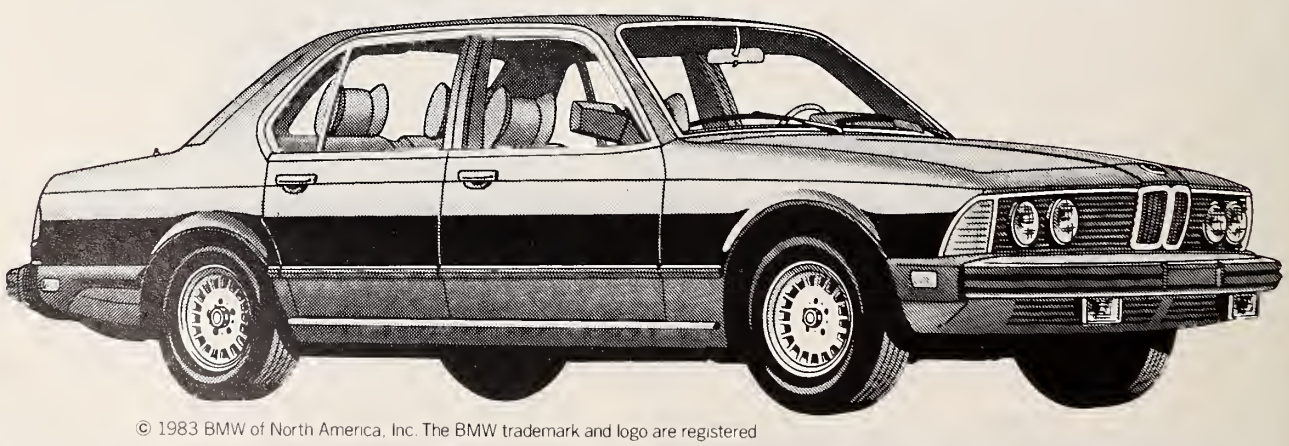
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The authors report two cases presenting as solitary thyroid nodules and briefly discuss the origins of the cysts.

Parathyroid Cysts

KENNETH ALONSO, M.D., MICHAEL PODOBNIKAR, M.D., ALEXANDER S. HARASZTI, M.D., PH.D., S. K. NAIDU, M.D., and S. L. MUHANNA, M.D., *Stockbridge

PARATHYROID CYSTS are rare. Because of their frequent clinical presentation as nodular or fluctuant masses in the neck, they usually mimic solitary thyroid nodules.[1] Often they are non-functioning. We report two cases presenting as solitary thyroid nodules and briefly discuss the origins of the cysts.

Case Reports

B.E.: The patient was a 26-year-old white woman with a large palpable nodule in the left lobe of the thyroid gland, first noticed by the patient 2 weeks prior to her physician visit. No pain was associated with the nodule. T4 was 8.4ug/dl; RT_3U was 28%. Serum calcium was 10.3mg/dl with a chloride/phosphorus ratio of 32.1. An iodine scan of the thyroid demonstrated a cold nodule in the lower lobe (Figure 1). Ultrasound demonstrated its cystic nature. The patient chose to have the lesion removed surgically.

W.B.: The patient was a 28-year-old white man with a palpable nodule in the left lobe of the thyroid gland. No pain was associated with the nodule. The nodule increased in size over a period of 2 weeks. T_4 was 7.3ug/ml; RT_3U was 34%. Serum calcium was 9.4mg/dl with a chloride/phosphorus ratio of 30.6. An iodine scan of the thyroid demonstrated a cold nodule in the lower lobe. The cystic nature was revealed by ultrasound examination. The patient elected to have the lesion removed surgically. The cyst was found impinging upon the recurrent laryngeal nerve.

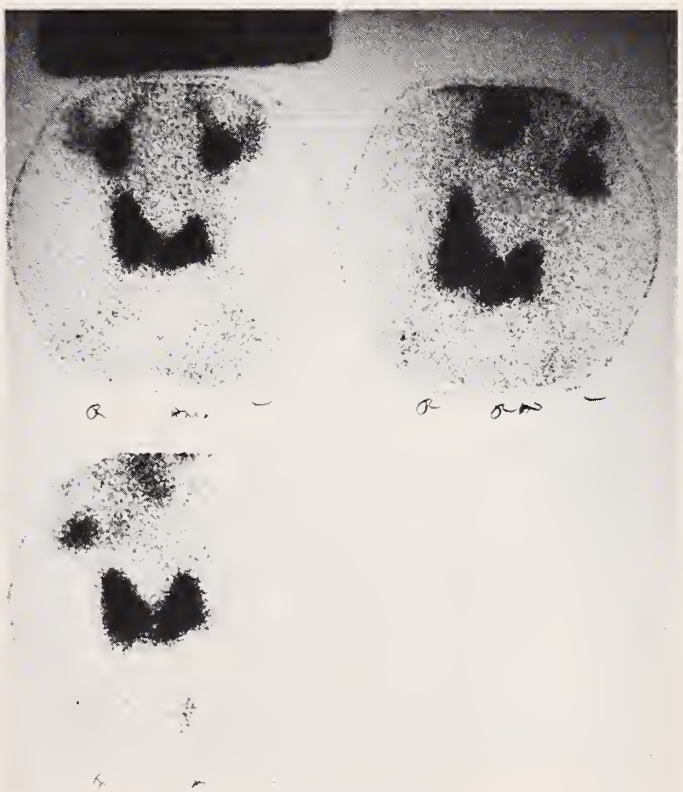


Figure 1 — Thyroid scan demonstrating focal diminished uptake in the left lower pole of the thyroid gland.

Light microscopy in these cases showed the inner surface of the cyst to be lined completely with a single layer of cuboidal cells compatible with chief cells (Figure 2). Immunoperoxidase staining was not helpful. Parathormone was examined in the contents of the fluid from the second cyst; it was present, though, in quantities at the lower limit of sensitivity of the assay employed. Little protein was found in the fluid.

* Dr. Alonso practices pathology, Dr. Podobnikar practices general surgery, Dr. Haraszti practices general and gynecologic surgery, Dr. Naidu practices internal medicine, and Dr. Muhanna practices vascular surgery. This paper was presented in part at the 76th Annual Meeting of the Southern Medical Association, Atlanta, GA, November, 1982. Send reprint requests to Dr. Alonso, Henry General Hospital, 1133 Hudson Bridge Rd., Stockbridge, GA 30281.



Figure 2 — H&E. 40X. Cyst wall demonstrating cords of chief cells.

Discussion

Solitary cysts containing clear serous fluid are occasionally found on either side of the neck attached loosely to the thyroid gland. At operation, 70-80 percent of the cysts are located in the lower portion of the neck. These cysts are thought to be related to the parathyroid gland because of location, cyst lining resembling parathyroid chief cells, and islands of typical parathyroid cells found in the cyst wall.

Larger cysts often contain parathyroid hormone and may reflect cystic degeneration of pre-existing adenomata. These are not felt to be true parathyroid cysts.[2]

One suggested cause of parathyroid cyst is thought to be embryologic remnants of the third or fourth pharyngeal pouch.[3] Consistent with this hypothesis, Troster[4] has demonstrated a lining of basic absorptive epithelial cells with little or no differentiation in the direction of any specific organ. Two other suggested causes are coalescence of microcysts and simple retention of parathyroid secretion in normal gland.[5] Miyauchi[6] has found a lining consistent with parathyroid chief cells in the cyst he studied. Chief cells are known to form acinal units.[7] Parathormone has been demonstrated in cyst fluid; low protein content is present.[8, 9] This is not found in normal glands.

The two cases presented resemble that of Miyauchi. The presence of small amounts of parathormone in cyst fluid are compatible with the conclusion that chief cells are present in the cyst. The absence of large amounts of hormone militates against a diagnosis of degenerating adenoma. The absence of microcysts in the wall of the cysts examined suggests an origin of simple retention of cyst fluid in an otherwise normal gland. The absence of abnormalities in calcium metabolism in these two patients also supports that conclusion.

Parathyroid cysts are unusual and often pose little diagnostic problem at microscopic examination. The current enthusiasm for aspirating thyroid cysts in lieu of removing them surgically probably contributes to the low incidence of recognition of parathyroid origin in the clinical setting.

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The authors outline a process for the procurement, processing, and freezing of viable cadaver skin for use as temporary wound coverage.

Recent Developments in Skin Banking and the Clinical Uses of Cryopreserved Skin

S. RANDOLPH MAY, Ph.D., JOSEPH M. STILL, JR., M.D., and WILLIAM B. ATKINSON, R.N., *Augusta

THE PRESERVATION of skin for transplantation began 180 years ago with the pioneering work of Baronio.[1] Since that time, more than 300 papers have been published on the preservation and use of skin on open wounds.[2] This sustained interest has stemmed from the excellent clinical results obtained with transplantable skin as a permanent autograft or temporary allograft wound cover, coupled with the ease of skin preservation and storage, either refrigerated or frozen. Indeed, skin is currently the only whole tissue which is routinely frozen by many facilities throughout the country for later use in the clinical care of patients. In this report, we will focus on recent developments in techniques for the procurement and banking of cadaveric allograft skin used for temporary wound coverage, with special attention to burn wounds.

The Clinical Need for Allograft Skin

While there has been increasing interest in research on collagen-based synthetic skin substitutes for the closure of extensive burn wounds,[3] most of the current commercially available synthetic wound dressings are made from adherent polyurethane (e.g., Op-Site®†). These polyurethane dressings are suitable only for the closure of uncontaminated partial-thickness wounds such as autograft donor sites.[4, 5] To date, viable cadaveric skin remains the dressing of choice for temporary grafting onto excised deep second-degree and third-degree burn wounds when an insufficient amount of autograft skin is present for complete wound coverage.[6] This conclusion is supported by numerous reports in the scientific literature substantiating the usefulness of cadaveric skin coverage for excised wounds.[2]

As a wound dressing, cadaveric allograft skin effectively (1) prevents contamination of the wound bed by environmental microorganisms; (2) decreases water, electrolyte, and protein losses; (3) reduces heat loss by impeding water loss from the open wound; and (4) decreases the pain associated with open wounds. The decreased pain level allows an optimum amount of patient ambulation and physical therapy to be undertaken.

The national yearly need for allograft skin for burn patient care has been estimated to be 3,000 m^2 (32,000 ft^2).[6] In the most recently reported survey, conducted in 1979,[7] 19 skin banking facilities stated that they obtained a combined total of 868 donors, or an estimated 410-560 m^2 (4,400-6,000 ft^2) of allograft skin in that year. Thus, the need for transplantable cadaver skin is five to seven times greater than the supply.

Skin Donor Selection Criteria

In order to provide skin capable of delivering physiologic wound coverage, skin banks must obtain contamination-free allograft which has re-

* Dr. May is Director of the Southeastern Burn Research Institute, and Associate Clinical Professor, Department of Surgery, Medical College of Georgia; Dr. Still is Director of the Burn Unit at Humana Hospital Augusta; and Mr. Atkinson is Coordinator of the Burn Foundation Skin Bank. This work was supported in part by a grant from the Burn Foundation, Inc. Send reprint requests to Dr. May at Southeastern Burn Research Institute, Humana Hospital Augusta Medical Plaza, Suite 303, 3623 J. Dewey Gray Circle, Augusta, GA 30909.

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tained a significant portion of its normal cellular viability and structural integrity. Fortunately, most hospitals rapidly transfer deceased patients to hypothermic storage (usually 4°C). This cold storage has been found to effectively maintain more than 50% of skin viability, and to inhibit enzymatic skin degeneration for 24 hours postmortem.[2, 8] Thus, skin useful for transplantation may be obtained up to 24 hours postmortem. This prolonged procurement time frame alleviates the need to deal with the heart-beating, brain-dead donors which are required for vital organ donation (although such donors are certainly not excluded for skin donation).

The advantage gained by the prolonged allowable procurement time postmortem contrasts with restrictions on the potential number of skin donors due to infection or sepsis. Prior to its removal, donor skin may be disinfected on its epidermal side by the use of topical povidone-iodine and 70% isopropanol, but no disinfectant other than parenteral antibiotic solutions may be applied to the dermal side of the removed skin, since strong chemical disinfectants kill the dermal cells, and chemically alter the structural integrity of the skin. Both of these outcomes have been noted to decrease the effectiveness of transplanted skin. Because of these constraints, the potential donor must be essentially contamination-free internally, i.e., he must not have possessed, at the time of death, any systemic microbial infection, diffuse dermatitis, treponemal-specific antibody or hepatitis-associated antigen in his serum, history of viral hepatitis or jaundice, or malignancy.[10] Table 1 lists the frequently encountered disease states and situations which are grounds to reject a potential skin donor.[6] Table 2 lists the items required for an initial screening of a potential skin donor.[6]

Deceased persons between the ages of 18 and 75 years who have not been excluded on the basis of disease states (Table 1) may be considered to be potential skin donors. A recent study in Philadelphia found that 4-7% of all deaths in 58 hospitals, and about 7% of all deaths examined by a county medical examiner, were acceptable for skin donation.[7] After acceptability is established, there is a requirement to obtain consent for the skin donation from the donor or the next-of-kin, either in writing or by means of a recorded message (such as a telephonic recording). With regard to the legal next-of-kin, the Georgia Anatomical Gift Act (Ga. L. 1969, p. 59, § 9.) states:

> When persons in prior classes are not available at the time of death and in the absence of actual notice of contrary indications by the decedent or actual notice of opposition by a member of the same or a prior class, any of the following persons, in order of priority, may give all or any part of the decedent's body for any purpose specified in Code Section 44-5-144 [medical or dental education, research, advancement of medical or dental science, therapy, or transplantation]: (1) The spouse; (2) An adult son or daughter; (3) Either parent; (4) An adult brother or sister; (5) A guardian of the person of the decedent at the time of his death other than the guardian *ad litem* appointed for such purpose; or (6) Any other person authorized or under obligation to dispose of the body.[11]

TABLE 1 — Listing of Frequently Encountered Disease States and Situations Which Are Grounds to Reject a Potential Skin Donor

Sepsis or bacteremia
Dermatitis or other infection of the skin
Pneumonia or other respiratory infection
Drug addiction or overdose (due to risk of hepatitis)
Jaundice
Toxic or viral hepatitis
Treponemal antigen or antibody
Malignancy, including sarcoma, carcinoma, lymphoma, and leukemia
Cancer chemotherapy or radiation therapy recipient
Poisoning
Leprosy
Undernourishment at death (difficult skin removal)
Autoimmune disease affecting integrity of the skin
Collagen disease affecting integrity of the skin
Burns greater than 50% of body surface area

TABLE 2 — Items to be Examined to Establish Acceptability of a Potential Skin Donor

Medical history and physical examination
White blood cell count and differential
Test for treponemal antibody
Test for Hepatitis B surface antigen and antibody
Liver function tests
Microbiology reports
Cause of death

The consent rate for requested skin donations from the 7% of acceptable donors obtained through a medical examiner in the Philadelphia study was found to be about 30%, which meant that the actual number of skin donations obtained in that case was 2% of all deaths screened.[7] Although a study has not been conducted on skin donation consents obtained by interested medical professionals in area hospitals, these consents may be an important source of donors.

Procedures for Skin Removal, Processing, and Cryopreservation

The surface of the skin is prepared sequentially with povidone-iodine detergent solution, sterile water rinse, povidone-iodine solution (wiped off with sterile gauze), and 70% isopropanol.[6, 9, 12] After the alcohol air dries, the body is draped to expose only the area from which skin is to be removed.

Sterile mineral oil is applied as a lubricating film, and 7.6-cm (3-in) wide strips of skin approximately 0.38 mm (0.015 in) thick are removed using a Brown or a Padgett electric dermatome. For the purpose of minimizing the potential that a portion of contaminated skin might cross-contaminate all or most of the other skin obtained from a donor, an independent-area protocol has been developed utilizing 10 defined donor body areas (left and right chest, left and right back, left and right hips, left and right anterior thighs, and left and right posterior thighs).[9] The skin strips removed from each of the 10 body areas are placed into separate screw-cap containers, covered with sterile nutrient medium, and stored on wet ice for transport to the skin bank.

The most widely used nutrient medium for skin storage is Eagle's Minimal Essential Medium/Earl's Balanced Salt Solution with 2 m*M* fresh glutamine and 10% (v/v) sterile pooled human sera added directly before use.[2] If antibiotic protection is desired, the most commonly used agent is a combination of 100 μg/ml streptomycin and 100 U/ml penicillin. The use of antibiotics is controversial due to the possibility of selecting resistant organisms which may then be transferred to the graft recipient and due to the lack of bacteriocidal action of many antibiotics at 4°C.[6, 9] A blood sample from the skin donor should be obtained by intraventricular cardiac puncture at the time the skin is removed.

The need for transplantable cadaver skin is five to seven times greater than the supply.

Ultralow-temperature storage maintains skin viability much longer than does refrigerated storage.[2] Skin may be effectively cryopreserved for ultralow-temperature storage by 4°C incubation in a nutrient medium incorporating a moderate amount of cryoprotectant agent, and then by slow cooling at −1°C/min prior to storage at −70°C or lower.[2, 6, 12] Frozen skin must be rapidly warmed at +100°C/min or faster prior to surgical application.[2, 6, 12] The natural flatness of skin provides an advantage in allowing uniform rapid heat flow throughout the tissue during cooling and warming.[12] Skin should never be rolled into a cylinder prior to cryopreservation, since this will defeat the inherent advantage of a flat geometry.

To prevent contamination of the skin, preparation for cryopreservation is carried out in a plenum laminar air flow sterile cabinet. First, skin strips are soaked for 30 minutes in the Eagle's Minimal Essential Medium described above to which 15% (v/v) glycerol has been added.[2] After soaking, the excess cryoprotectant solution is wiped from the skin. A 1-cm^2 biopsy for microbial assessment is cut from a single strip of skin from each of the containers corresponding to an independent body area.[9] The skin strips are cut to a 7.6 cm x 20 cm (3 in x 8 in) dimension, and fine-meshed gauze is placed on both the dermal and epidermal sides of the skin. Each skin strip with gauze is folded in half over the 7.6-cm edge of a 7.6 cm x 20 cm rigid plastic package stuffer, and inserted into a 10 cm x 15 cm 4.5-mil polyester film packet (Kapak Korp., Bloomington, MN).[12] The package stuffer is removed, and the open end of the packet is heat sealed, protecting the enclosed skin from contamination during further handling.

Since five or six dozen packets of skin are obtained from a single donor, most modern skin banks use commercially-available preprogrammed or programmable controlled-rate freezers with large-volume freezing chambers.[12, 13] These units are capable of freezing the skin from a single donor at a steady rate of −1°C/min from room temperature to −70°C or below. At that temperature, the skin packets may be transferred to ultralow-temperature storage in a mechanical biologic freezer (−70°C to −85°C) or in liquid nitrogen (−196°C).

If a controlled-rate freezer is unavailable, skin may be frozen by nonoverlapping placement of three packets between two 20 cm x 30 cm x 1.6 mm aluminum plates which are subsequently placed in a box whose walls are 2.5 cm-thick expanded polystyrene, and then cooled by placing the box in a freezer set to a temperature of −70°C.[14] This is a very simple technique for the cryopreservation of skin, and will allow many medical facilities the advantages of non-degenerative skin storage. The technique is useful for both cadaveric allograft skin and any autograft skin remaining from a surgical procedure.

Microbiologic Assessment

The microbiologic cleanliness of skin is assessed by homogenizing each of the skin biopsies obtained from the independent body areas in 2 ml of saline and placing aliquots onto Chocolate and Blood agar plates for bacterial colony counts, onto Lowenstein-Jensen agar slants for tuberculosis tests, and onto Sabouraud dextrose agar slants for fungal detection. The donor blood sample is tested for Hepatitis B surface antigen and antibody, and for antitreponemal antibody. No skin from donors with hepatitis or syphilis is transplanted onto burn patients, nor is skin used from any donor body area whose biopsy shows detectable bacterial or fungal contamination in the agar tests. Published results have demonstrated that typical cadaveric skin contamination rates are 6% with non-pathogenic bacteria, 3% with Hepatitis B virus antibody (none with antigen), 1%

with pathogenic bacteria, 1% with yeast and fungi, 1% with antibodies to *Treponema pallidum,* and none with tuberculosis.[9] With careful donor body preparation, 92% of cadaveric allograft skin may be obtained contamination-free by microbiologic test.[9]

Clinical Application

Table 3 lists the effective uses of cryopreserved viable cadaveric skin.[6] Although allograft skin should be replaced at frequent intervals when it is used to cover chronic or contaminated wounds, if it is applied to clean wounds such as excised uninfected burn wounds, it may be allowed to "take," or become neovascularized. In patients with large thermal injuries, immunologic rejection of allotypic skin grafts is considerably delayed, presumably due to the suppression of the immune response caused by the thermal injury. This immunosuppression allows for a prolonged period of effective allograft skin coverage, about 14 to 45 days. Of course, the allograft should be removed and replaced at the first sign of infection or immunologic rejection. If rejection begins to occur, then the replacement graft should be skin from a different donor than was used in the first instance. Skin from a second donor will have a high probability of possessing a different HLA type, which will preclude a rapid rejection response (second-set rejection) due to previous sensitization by the initial graft.

Cadaveric allograft skin effectively prevents contamination of the wound bed by environmental microorganisms and decreases water, electrolyte, and protein losses.

To maintain its viability, skin must be warmed rapidly after removal from ultralow-temperature storage. When using our system, the packets of skin are placed in 10°-37°C water, and warming is completed in 15-30 seconds.[12] The skin warming rate is +127°C/min if 10°C water is used, and +470°C/min if the water temperature is 37°C.[2, 6] Care must be taken to avoid using a water temperature greater than 37°C, since it will damage the skin and decrease its viability by a significant amount.[2, 6]

After warming, the packets are wiped free of excess water and are torn open at the level of their molded notches. Forceps or hemostats are used to remove the skin in its protective gauze covering from the packet. The skin is then rinsed sequentially in three bowls of sterile isotonic saline, and is allowed to remain in the final rinse until application onto the recipient patient. The skin should not be left for prolonged periods in the final rinse, since osmotic damage may occur to the skin cells.

TABLE 3 — Uses of Viable Cryopreserved Cadaveric Allograft Skin

Debrided or surgically excised thermal and electrical injuries
Partial-thickness autograft skin donor sites and pedicle flap donor areas
Traumatic wounds such as degloving accidents
Fresh reepithelializing or granulating wounds
Mature granulated wounds to determine their suitability for autografting
Temporary coverage of muscle or tendons exposed by a decompression fasciotomy
Contaminated chronic wounds such as decubitus ulcers

After a wound is excised to punctate bleeding, undiluted topical thrombin (Thrombostat®)* is then applied, and the wound is covered with a towel to prevent contamination. Unmeshed allograft skin is applied to the wound dermal-side down after the removal of the gauze covering that side. The skin is positioned on the wound, and any air bubbles or fluid are expressed to the sides of the graft. The epidermal-side gauze is removed, and the skin is held in place with adhesive strips and spray adhesive, or sterilized nylon netting secured by surgical staples. The grafts should be left uncovered or else dressed with protective bulky gauze held in place with surgical elastic net. Freshly applied allotypic skin should not be prematurely redressed. If possible, the skin should remain in place for 5 days to allow for good graft adherence and neovascularization before redressing is attempted.

Summary

Modern skin banking techniques are capable of providing long-term storage of cadaveric skin while preserving its cellular metabolic function and structural integrity. Allotypic skin from cadaveric donors is the dressing of choice for large thermal and electrical injuries. The recent development of effective techniques for skin cryopreservation and the establishment of skin banks, coupled with the help of medical professionals in educating their terminally ill patients concerning the importance of organ donation, have significantly improved the care of burn patients through the increased availability of transplantable skin. The techniques we have developed can also effectively be used by clinicians in medical situations unrelated to burns; specifically, in the treatment of acute trauma, in plastic and reconstructive surgery, and even in some types of general surgery.

(References listed on p. 257.)

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This episode is a reminder of the potential for spread of hepatitis A among children enrolled in day care programs and for waterborne transmission.

Hepatitis A, a Day Care Home, and a Contaminated Well

JAMES W. BUEHLER, M.D., J. DAVID SMITH, B.S., THOMAS W. McKINLEY, M.P.H., and R. KEITH SIKES, D.V.M., M.P.H., *Atlanta**

Abstract

In May-July 1982, an outbreak of hepatitis A occurred in a rural community in south Georgia. Nine out of 10 persons with laboratory-confirmed cases of hepatitis were children or contacts of children enrolled in a family operated day care home that had a private well as its source of water. All 10 persons had consumed water from the same well. Water specimens from the well showed evidence of fecal contamination, and the pattern of disease occurrence was consistent with a common source infection. Although consumption of water appeared to be a likely source of infection, direct person-to-person transmission of hepatitis A may have occurred among persons involved in day care. This episode is a reminder of the potential for spread of hepatitis A among children enrolled in day care programs and for waterborne transmission of this disease.

TRANSMISSION OF HEPATITIS A virus (HAV) in day care centers, where fecal-oral spread of the virus is facilitated by congregation of children in diapers, is a recognized community problem.[1, 2] Because infection with HAV is often asymptomatic or produces non-icteric illness in infants and children, hepatitis A (HA) outbreaks in day care centers may not be recognized until cases occur in adults who work at or have children enrolled in day care centers.[1] In June, 1982, a small outbreak of HA occurred in a rural community in south Georgia. Nine of 10 persons with HA cases were children who attended a family operated day care home, household contacts of these children, or members of the family in whose home day care was provided. This day-care-associated outbreak of HA was unusual, however, because consumption of water from a contaminated well supplying the day care home may have been the predominant source of infection. This observation, however, should not overshadow the more common public health problem represented by person-to-person transmission of HAV in commercial centers or private homes offering day care for infants and children.

Background

The outbreak occurred in the principal town of a rural, south Georgia county with a population of approximately 12,000 persons. On June 21, 1982, a physician reported that all five members of a family (Family A) had become ill during the preceding week. The two adults, ages 30 and 34 years, had been admitted to the local hospital with signs and symptoms of viral hepatitis, and their children, ages 5, 7, and 9 years, had a milder illness consisting of fever, headaches, or vomiting lasting 2-3 days. The mother in Family A managed a small, non-licensed day care operation in her home. In keeping with state regulations that require licensure for centers with seven or more children, there were six or fewer regular attendees. The water supply for the family was from a private well which served two households.

* Dr. Buehler is with the Division of Reproductive Health, Centers for Disease Control, and Mr. Smith, Mr. McKinley, and Dr. Sikes are with the Georgia Department of Human Resources. Send reprint requests to Mr. Smith, Office of Epidemiology, Georgia Department of Human Resources, 47 Trinity Ave., Atlanta, GA 30334.

Methods

Cases of HAV infection were identified by contacting local physicians, the county health department, and families of children who had received day care in Family A's home. For these children, for members of Family A, and for members of the neighboring family who used water from the same well, information was obtained concerning symptoms of illness among all household contacts. Serum specimens were collected from each day care child and others with suspected HAV infections, and serologic tests for HAV infection were performed using standard radioimmunoassay methods by a local private laboratory or by the Hepatitis and Viral Gastroenteritis Division, Centers for Disease Control, Phoenix, Arizona. Any community resident with detectable IgM-phase antibodies to HA and with onset of symptoms in May-July 1982, was considered to have an outbreak-associated case of HA.

Water specimens were collected by the local sanitarian from Family A's well and from other wells in the neighborhood. Fecal coliform counts were done by the Water Laboratory, Georgia Department of Natural Resources.

Results

Hepatitis Cases

Ten cases of HA were identified (Figure 1). All occurred in children who were enrolled in day care at Family A's home and others who had direct contact with these children or had consumed water from the well serving the day care home. HA cases occurred in the following groups:

1. *Children attending day care at the home of Family A:* The first case occurred in a 5-year-old boy who had a fever that lasted 3 days. He was described as an active child who frequently engaged in close contact with other children. Approximately 1 month later, a second case occurred in a 2-year-old boy who had fever and vomiting (coincident with illness in Family A).

   Eight other children, ages 5 months to 4 years, had attended day care during the month preceding onset of illness in members of Family A. Of the 10 day care children, six were daily attendees, and four had attended for 1 day only. Both children with HAV infections were daily attendees. Although all six daily attendees had had fever, vomiting, and/or diarrhea at varying times during this period, only two had positive serologic tests for HAV infection. All day care participants consumed water from Family A's well, but information concerning frequency or amount of water consumed was not collected.

2. *Family A:* All five members of Family A became ill approximately 1 month after the first case in a day care child. The mother in Family A was directly responsible for the day care operation. She supervised the children, provided meals, and changed diapers. Her three daughters had informal contact with day care children, often playing with them in the afternoons. Her husband had infrequent contact with day care children.

3. *Family B:* Five weeks after the first case, the two adults in Family B developed symptoms of hepatitis, and HA was confirmed in both. They had had frequent social contact with members of Family A and had often drunk water at the home of Family A. Their 6-month-old baby (a daily attendee of day care at Family A's home) was hospitalized because of gastroenteritis, but antibodies to HAV were not detected in his serum. The mother in Family B also had occasional contact with other day care children.

4. *Family C:* Six weeks after the first case, a 24-year-old man had onset of symptoms of HA — the same day that he and his parents received immune globulin prophylaxis. He had no contact with Family A members, children enrolled in day care, or others with suspected HAV infection. His parents, with whom he lived, did not become ill and declined serologic testing. Family C lived in the other home that received water from the same well as Family A.

   Except for one mother, no other acute illnesses were reported among household contacts of day care participants. She had a mild gastrointestinal illness during the week that members of Family A were ill, but her serologic tests were negative for HAV infection.

   None of the children with HA but all of the adults developed clinically apparent symptoms of HA including jaundice.

Environmental Testing

Water collected from Family A's well immediately following the case report had >16 fecal coliforms (most probable number [MPN])/100 ml, and repeat specimens showed evidence of persistent contamination. The well, constructed 8 years earlier, was a 3-inch diameter drilled well with a depth of approximately 70 feet. It was located 75 feet from the family's septic tank and >100 feet from the septic tank tile field.

Water specimens were tested from eight other wells in the neighborhood, and fecal coliforms (5 MPN/100 ml) were detected in one. No cases of illness were associated with consumption of water from this well.

Control Measures

The day care operation was discontinued. Immune globulin was recommended for children in the day care group, their household contacts, and per-

sons living in homes supplied by the two contaminated wells. The family served by these wells were advised temporarily to boil drinking water. Family A's well was chlorinated, but fecal contamination continued. A new and deeper well was drilled, and water specimens were periodically monitored by the local health department. Chlorination of the other, mildly contaminated well was successful in eliminating contamination.

Discussion

Person-to-person transmission of HAV in day care centers is an important public health problem.[1, 2] This outbreak was unusual because waterborne transmission was suspected. The pattern of disease occurrence, with relatively simultaneous onset of HA among persons 4 to 6 weeks following an initial case (Figure 1), suggests a common source of infection. However, since most of the persons with cases were potentially exposed to the day care child who first became ill, it was not possible to determine whether the infection was acquired by direct contact with an infectious individual or by consumption of contaminated water. There was at least one case for which waterborne transmission appeared most probable. This occurred in an adult whose house was supplied with water from Family A's well and who had no other known exposure to hepatitis.

None of the infants or children with HA developed jaundice, and all had mild, nonspecific symptoms. In contrast, the five adults with HA had icteric disease, and four were admitted to hospitals. Because children with HA typically have non-icteric disease, diagnosis of clinically apparent HA in adults may be the first indication of a day-care-associated outbreak.

When a clinical diagnosis of hepatitis is made, serologic tests should be done to determine the specific type. Currently, readily available serologic tests can be used to diagnose hepatitis types A and B; type nonA-nonB remains a diagnosis of exclusion. HAV infection is confirmed by the presence of antibodies to HAV; current or recent infection is distinguished from past infection by the presence of IgM-phase antibodies which appear coincident with the onset of acute symptoms and remain detectable for 1-3 months. Convalescent-phase (IgG) antibodies remain detectable indefinitely. Although the various forms of viral hepatitis are clinically indistinguishable, they differ in prognosis and preventive strategies. Physicians are urged to report hepatitis cases to local public health officials to insure that appropriate preventive measures are done. In this outbreak, the investigation and institution of control measures were facilitated by a timely report from a concerned physician and by the cooperation of

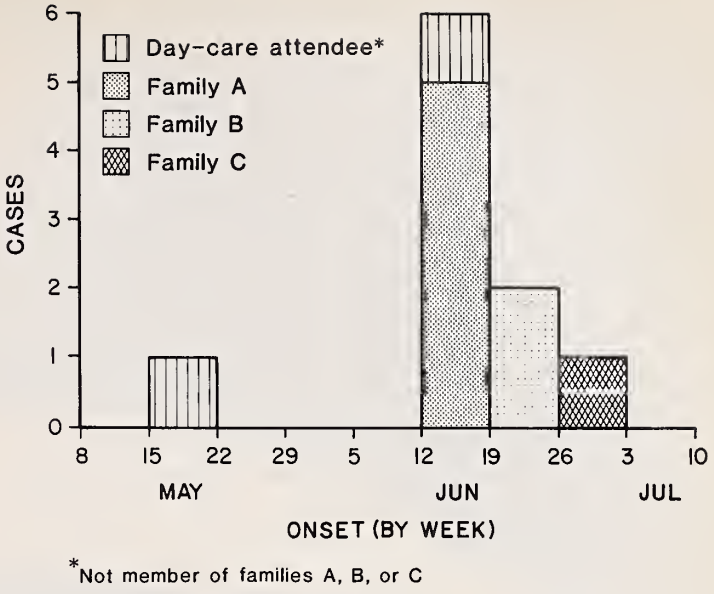


Figure 1 — Cases of laboratory-confirmed HA in residents of a rural community, south Georgia, May-July 1982, by week of symptom onset. Day care attendees with HA were not members of Families A, B, or C.

physicians in the community. Similarly, operators of day care centers should report any suspected outbreak of disease among children or staff.

Because of the potential for spread of HAV in day care centers, it is important to inquire whether HA patients are enrolled in or have contact with children enrolled in day care centers. The response to an HA case in a day care center depends on the age of children in the center and the degree of spread at the time the problem is recognized.[1, 3] Because the likelihood of spread is greatest in centers that enroll children in diapers, immune globulin should be administered to all children and employees when a case occurs in such a center. If epidemiologic evidence indicates that transmission of HAV has occurred in the center, as demonstrated by cases in several children, employees, and household contacts, then immune globulin should also be administered to all household contacts of diapered day care children — measures employed in this outbreak where initial findings demonstrated occurrence of HA in children, parents, the day care operator, and her family. If the center does not enroll children in diapers, use of immune globulin may be limited to children and staff who have close personal contact with persons with HA. Proper attention to hand washing and other hygienic measures is essential, particularly after changing diapers and preceding the preparation and serving of meals.

Consumption of contaminated water is another recognized mode of HAV transmission.[4] This was the first of two HA outbreaks in Georgia in 1982 for which waterborne transmission was suspected, and both involved private wells in areas where sewage

from homes was disposed into septic tanks.[5] In this outbreak, the well was in compliance with state and local regulations which require that private wells be located at least 50 feet from septic tanks. Chlorination was unsuccessful in eradicating contamination, and construction of a deeper well was necessary to provide a safe water supply for the affected families.

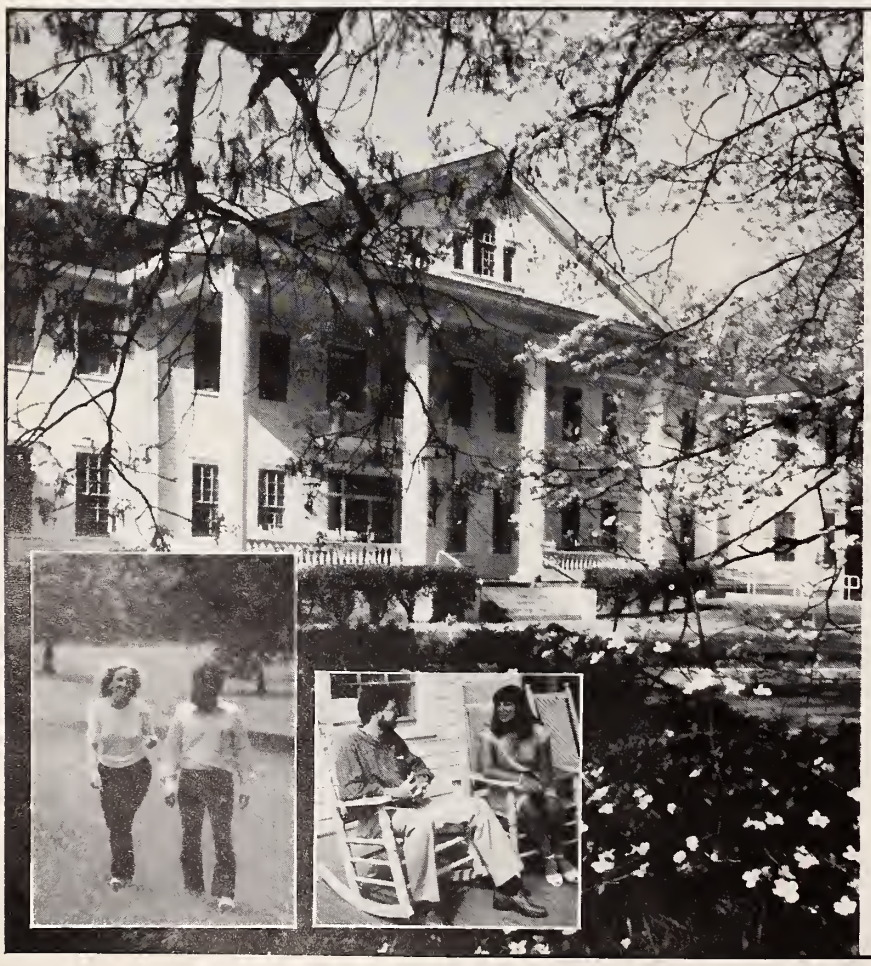
Physicians and health departments should remain alert to the possibility of day care and waterborne HAV transmission. This outbreak was unique because it may have involved both person-to-person and waterborne transmission. As the number of young children enrolled in day care centers and the number of private wells increase, opportunities for both modes of HAV transmission will undoubtedly increase in Georgia.

Acknowledgments

Truman L. Vasko, M.D., Montezuma, first reported the outbreak. Others who assisted in this investigation included Jack A. Butler, M.D., Unadilla; Joseph T. Christmas, M.D., Vienna; Teresa Tripp, M.D., Cordele; Leah R. Camp, M.D., Frances Collins, R.N., Health District 7, Columbus; Mary King, R.N., Lawrence Nutt, Dooly County Health Department; Stephen C. Hadler, M.D., Centers for Disease Control, Phoenix, Arizona; William McLemore, Ph.D., Georgia Department of Natural Resources, Atlanta; and Mark Vasko, Montezuma.

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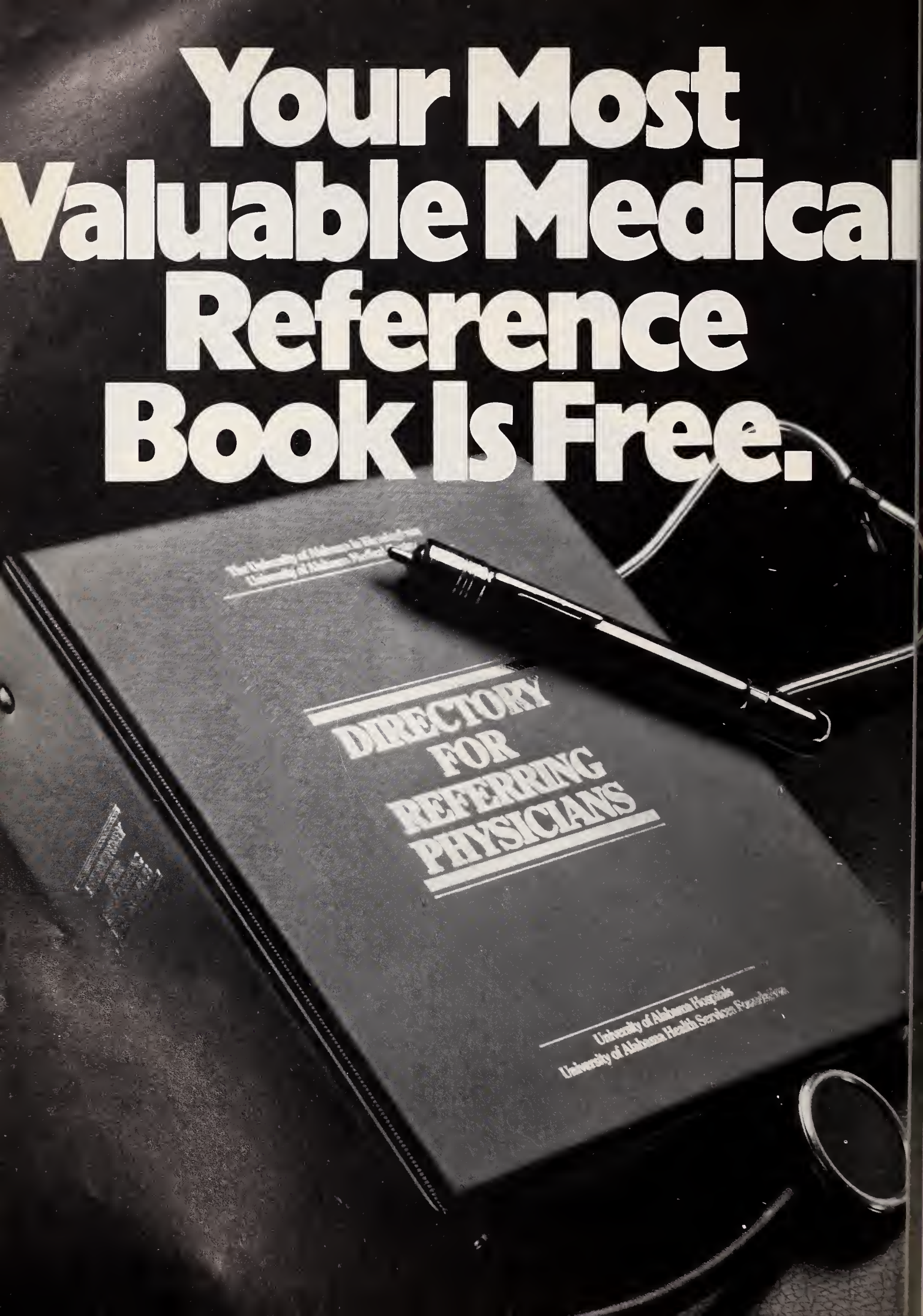
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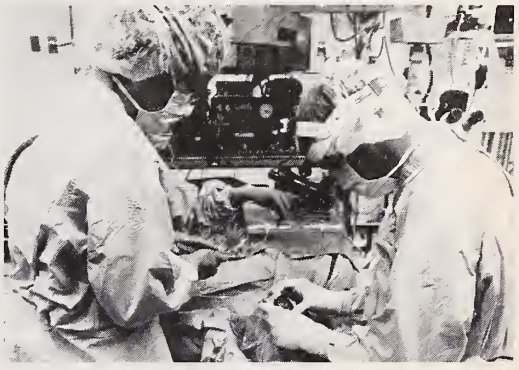
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Welcome to the game "Not-So-Trivial Pursuits"! You have chosen the category of Famous Disease. Your question: Which disease matches the following description?

1. The most common of all diseases (afflicts over 37 million adult Americans).
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3. Does not cause symptoms until late in its course (known as the "Silent Killer").
4. Readily available treatment can greatly reduce the morbidity and mortality of this disease (the mortality rate has fallen by 80% since 1948).

ANSWER: (see article on page 217)

Although this information is now well known to physicians, the importance of recognizing and treating mild to moderate hypertension was not widely appreciated until 1970 when extensive clinical studies done in Georgia and elsewhere documented a 20% prevalence of this disease and the beneficial effects of treatment. Since then, efforts have been successful in educating the public and detecting high blood pressure through increased physician awareness and mass screening. School programs developed by the American Heart Association in Georgia have discovered hypertension in early stages and have taught children how to take the blood pressures of their parents.

Physicians have learned that the "hypertensive workup" is not necessary in the vast majority of patients; that stepped-care therapy is effective and generally well tolerated; and that systolic hypertension has adverse effects in the elderly. Despite an increased awareness of hypertension and its consequences by patients and physicians, several frustrating problems persist:

1. Some physicians dismiss mild or labile hypertension or often do not measure blood pressure.
2. Guidelines for confirming hypertension with multiple measurements on several visits are not followed, leading to unnecessary treatment in some patients.
3. Recommendations for treatment are not always followed.
4. Physicians sometimes stop treatment when the blood pressure has become normal.
5. Patients may stop treatment believing that their illness is cured.

In this issue of the *Journal,* Drs. McClellan, Wilber, and Hall discuss these problems and provide important data on the pattern of hypertensive diagnosis and treatment practiced by physicians in Georgia. For those physicians who are interested in pursuing this not-so-trivial illness, I recommend that you read their conclusions and consider their recommendations.

Mark E. Silverman, M.D.
Cardiologist, Atlanta

legal page
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An Infant's Right to Die: Must Physicians, Hospitals, Parents, Guardians, Attorneys, Clergymen, Review Committees, Government Representatives, *And The Courts* Be Involved in the Determination?

ROBERT N. BERG, *Atlanta**

THE GEORGIA GENERAL ASSEMBLY, during its 1984 Session, passed what was known as the "Living Will" Bill.[1] This Bill would allow a person, by executing a document called a "Living Will," to evidence his or her intention that physicians or hospitals *not* provide life-sustaining treatment in the event that he or she is inflicted with a terminal condition.

The case described in this article provides, figuratively, a road map of how physicians and hospitals may safely make and implement right-to-die decisions.

The drafters of the Living Will Bill recognized that the provisions of that Bill would not provide a complete solution. Practically, the Bill's provisions would come into play only in two situations: (i) when the person involved had executed a written directive instructing his or her physician to withhold or withdraw life-sustaining treatment in the event of a terminal condition, and, subsequently, that person was unconscious or otherwise not competent to express his or her wishes; and (ii) when a competent, conscious patient in a hospital, complying with the numerous requirements, executed a Living Will instructing his or her physician to "pull the plug." The Bill does not, however, deal with the equally common situation which physicians and hospitals will face — how does one decide whether or not to withdraw or withhold life-sustaining treatment from a comatose patient who has not executed a living will or from an infant who is not competent to do so?

An extraordinary declaratory judgment action recently brought before Judge Hilton Fuller of the DeKalb County Superior Court on behalf of a 4-month-old infant girl evidences the complexity of the issues involved and the nature of the convoluted procedures which at present must be utilized in dealing with right-to-die questions. At the same time, Judge Fuller's order raises some hope that future right-to-die decisions may be made on the basis of some delineated guidelines or standards, and, more importantly, may be made without the necessity of involving the courts.

* Prepared at the request of the Medical Association of Georgia. Mr. Berg is an associate in the firm of Powell, Goldstein, Frazer & Murphy, General Counsel to the Association, 1100 C & S National Bank Building, Atlanta, GA 30335.

The Problem: Must Physicians and Hospitals Provide Life-Sustaining Treatment to Terminally Ill Infants?

The case before Judge Fuller[2] involved an infant born on October 11, 1983, at term, and identified only as "L.H.R." Although L.H.R. was healthy at birth and for the first 2 weeks of her life, she became comatose following an unidentified "medical catastrophe." L.H.R. was admitted to a hospital where brain scans revealed bleeding into the brain. An operation was performed, but L.H.R. never regained independent breathing, and she was dependent upon a respirator from October 27, 1983. She also developed numerous complications.

Ultimately, L.H.R. was transferred to Henrietta Egleston Hospital for Children in Atlanta (the "Hospital"). At that time, the Hospital's evaluation revealed that L.H.R. could not breathe without continuous assistance from a respirator; that there was no evidence of visual responsiveness, or response to any sort of auditory stimulus; that there was paralysis of her facial muscles, her pharynx, and tongue, such that she had no ability to close her mouth or swallow; and that there was no evidence of nerve function in those nerves originating in the middle and lower brain stem. Further brain scans were also performed, indicating that 85 to 90 percent of the brain tissue had been irreversibly destroyed and that there was no clinical evidence of brain stem function.

In fact, L.H.R. technically could have been classified as "brain dead,"[3] but for one complication — she did have some sensory perception, in that she experienced random, purposeless, superficial movements. As a result, while L.H.R. existed in a chronic vegetative state, and, according to her physicians and the Hospital, would continue to do so forever, she could not be technically classified as "brain dead."

After 3½ months of intensive treatment and care, L.H.R.'s physicians recommended that she be taken off the respirator and allowed to die. L.H.R.'s parents and natural guardians, as well as a guardian appointed by the court,[4] concurred. In addition, a review committee established by the Hospital and composed of two non-treating medical doctors, a non-treating registered nurse, a social worker, a parent of a handicapped child and a hospital administrator, also agreed. Since L.H.R. was not "brain dead" under the Hospital's rules, however, the parties proceeded to the Court to obtain an order authorizing them to take L.H.R. off the respirator.

Following the requested hearing, Judge Fuller ordered that the Hospital "may honor the wishes of L.H.R.'s parents and guardians to have life support systems discontinued." Later that afternoon, the Hospital did so, and L.H.R. died.

The Legal Analysis: An Infant's Constitutional Right to Demand Withdrawal of Life-Sustaining Treatment

Judge Fuller, in reaching his decision, was required to analyze a series of difficult legal issues. His analysis commenced with the determination that "a competent adult, critically and terminally ill, has the right to insist upon the discontinuance of life support systems artifically maintaining his life. The failure to honor such an insistence constitutes a violation of the patient's rights to privacy and self-determination." In fact, Judge Fuller had made that exact determination mere months before when, following a bedside hearing at a hospital, he ordered the hospital to comply with a request to remove a conscious, terminally ill patient from life support systems.[5]

Of course, L.H.R. was not a competent adult, she was an incompetent minor. Thus, the next two legal issues with which Judge Fuller had to deal: whether an incompetent person has fewer rights than a competent person, and whether parents, as natural guardians, are entitled to exercise rights on behalf of their incompetent child? On the first issue, Judge Fuller found that the question of competency has little bearing on a person's right of privacy, citing, among other cases, the well known case involving Karen Quinlan.[6] According to that and other cases, the right of privacy must extend to the case of an incompetent, as well as a competent, patient because the value of human dignity extends to both.[7]

On the other issue, Judge Fuller found that L.H.R.'s parents, as her natural

guardians, had the power to exercise the rights of privacy and self-determination on her behalf.

Finally, Judge Fuller considered whether the State had any interest which might outweigh the constitutional and other rights of L.H.R. He found no such State interest, finding that, "by any reasonable standard there was no 'life' to preserve. Preserving what was left [of L.H.R.'s life] would be an affront to human dignity." Accordingly, Judge Fuller ordered that L.H.R. be removed from life support systems.

Safeguards Utilized by the Court and Hospital in Reaching Their Decision

In reaching his decision, Judge Fuller chose to adopt a number of "safeguards" to allow for a complete assessment of the medical and legal procedures involved in the case. As noted above, Judge Fuller appointed a special guardian for L.H.R., so as to determine that neither the medical community nor L.H.R.'s parents had any interest adverse to those of L.H.R. Though there was not the slightest hint of any such adverse interest, Judge Fuller acknowledged that circumstances could be imagined, for example, where parents, simply unable to bear the financial and/or emotional strain, chose to act primarily for their own interests, rather than for those of their child. Similarly, under certain circumstances, termination of life support systems could be viewed as being in the interest of certain members of the medical community "who might be interested in ending or reducing the possibility of potential discussions concerning mistakes in diagnosis and/or treatment."

Judge Fuller also notified the United States Attorney, the Attorney General of Georgia, and the District Attorney of DeKalb County and provided them with an opportunity to intervene. Ultimately, each declined to do so.

In addition to the legal safeguards which Judge Fuller adopted, a number of "medical safeguards" were instituted by the Hospital and physicians, including: (1) L.H.R. was re-evaluated at the Hospital; (2) the attending physician, after numerous tests, concluded that L.H.R. was in a chronic vegetative state with no hope for recovery or improvement; (3) a consulting neurosurgeon agreed with the attending physician; and (4) the Review Committee of the Hospital unanimously concurred with the parents' request and the medical recommendations that life support measures be withdrawn.

Guidance for Future Right-to-Die Decisions

In his order, Judge Fuller expressed his regret at the fact that, despite all of the safeguards employed, "the parents, the hospital, and physicians were forced into court with all of the attendant emotional and financial expenditures as well as the resulting continued violation of the rights of L.H.R." More to the point, Judge Fuller recognized that there was a means for rectifying this unfortunate situation: "The subject matter confronted by this case screams for thoughtful and deliberate evaluation [by the Georgia appellate courts] with a view toward the development of guidelines and procedures making unnecessary judicial intervention in every case of this nature." In other words, it was up to the courts, in Judge Fuller's view, to establish guidelines so that parents, hospitals, and physicians may be able to make and carry out right-to-die decisions without the necessity of involving the courts.

In furtherance of this end, Judge Fuller took the extraordinary step of adding the Attorney General of the State of Georgia as a party to the proceeding and requesting that he appeal Judge Fuller's order so that the Georgia appellate courts might have an opportunity to provide the much needed guidance. The Attorney General apparently has accepted Judge Fuller's invitation and agreed to make such an appeal.

Hopefully, the Georgia appellate courts also will accept Judge Fuller's invitation. If so, "(p)hysicians and other members of the medical community [might] be free to honor the wishes of those exercising their rights of privacy and self-determination, or those of their wards, without the possibility of civil and/or criminal liability, provided certain non-judicially supervised (at least on a case-by-case basis) guidelines are followed." *(Notes listed on page 257.)*

The Coronary Artery Surgery Study (CASS) — Widely Misinterpreted

SPENCER B. KING, III, M.D., *Atlanta**

RANDOMIZED CONTROLLED trials have been performed to assess the efficacy of coronary artery bypass graft (CABG) surgery in comparison with medical therapy. In order to identify which patients will benefit most from CABG surgery, various subgroups of patients have been studied. The most recent effort in that direction was the widely reported Coronary Artery Surgery Study (CASS).[1] Reports in the lay press concerning this study would have us believe that patients with mild symptoms can be followed on a medical regimen and that surgery can be deferred for as long as 5 years with no decrease in survival. This conclusion, however, is based on a misinterpretation of CASS.

Description of CASS

CASS was a multi-institutional research program which consisted of a randomized trial of medical versus surgical treatment of coronary artery disease and a larger registry of patients who underwent diagnostic evaluation for coronary artery disease. A total of 18,894 men and 6,065 women underwent coronary arteriography at 15 CASS clinics. At the 11 sites which participated in the randomized study, 16,626 patients in the registry were eligible for entry into the randomized trial. Patients were rejected from randomization for various reasons. Twenty-eight percent were normal, 5% were inoperable because of disease in the distal vessels, 36.5% had class III or IV angina, and 4.3% had severe left main stenosis. An additional 16% were excluded because of prior surgery, ejection fraction less than 35%, severe congestive heart failure, age over 65 years, or any problem which would complicate follow-up. This left 2,099 patients eligible for randomization. Of that number, 1,219 did not participate either because the physician or the patient refused. The 780 remaining patients were randomly assigned in equal numbers to medical and surgical treatment groups and followed accordingly.

The planners of the study predicted a 4% annual mortality in the medical group. They expected that if surgery produced a large reduction in mortality, this would be revealed. Surprisingly, the mortality in the medical group was only 1.6% per year. There was no significant difference in mortality between the two groups. Why such a low mortality in the medical group?

Factors Contributing to Low Mortality in the Medical Group

The mortality in medically treated patients in the European Cooperative Study[2]

* Dr. King specializes in cardiovascular disease. Send reprint requests to him at Emory University Clinic, 1365 Clifton Rd., NE, Atlanta, GA 30322.

Articles for this Page are sponsored and approved by the American Heart Association, Georgia Affiliate. Those wishing to contribute papers to this Page are invited to send them to Dr. Laurence O. Watkins, "Heart Page" Editor, Section of Cardiology, Dept. of Medicine, MCG, Augusta, GA 30909.

was 3.3% per year and in the VA study,[3] 4.3% per year. Why, then, such a low risk for those patients assigned to the CASS? The answer lies in the process of patient selection for the CASS. Patients in the large CASS registry, from which this randomized study was drawn, had mortality risks which varied according to their baseline characteristics: from 1.3% per year for single vessel disease with normal left ventricular function to 12.5% per year for three vessel disease with impaired left ventricular function. The 780 patients who entered the CASS randomized trial were highly selected not only on the basis of mild symptoms but also with knowledge of the coronary arteriogram and left ventricular function. This selection process yielded 780 patients of whom 27.4% had single vessel disease and 39.5% double vessel disease. In addition, 75-80% of the patients had ejection fractions above 50%, and 71.7% of the patients did not have obstruction of the proximal left anterior descending coronary artery. Each of these conditions is a marker for favorable long-term prognosis.

Another factor which may have contributed to the 1.6% annual mortality in the medical group is the fact that as their symptoms worsened, 23% of the medical group underwent CABG surgery during the follow-up period. However, for analysis, they were kept in the medically assigned group. If surgery improved survival, this analysis, though statistically appropriate, made it less likely that a difference would be detected.

The authors calculated the sample size required to detect statistically significant differences between the groups. In the total group, if the annual mortality of 1.6% for the medical group and 1.1% for the surgical group held, then it would be necessary to randomize 4,600 patients to show this 30% difference with a p value of .1. In the subgroup with three-vessel disease and impaired left ventricular function, the 5-year survival with medical therapy was 80% and with surgical therapy was 90%. This marked 50% improvement in survival would require 650 cases to be randomized in order to demonstrate a statistically significant difference at the $p = .1$ level. Only 78 patients with these characteristics were randomized.

The survival data provide only one aspect of the study. In this randomized study, the investigators found that compared to the medical group the surgical group experienced an improved quality of life as manifested by relief of chest pain, improvement in subjective and objective measurements of functional status, and decreased requirement for drugs.[4]

CASS was a carefully executed evaluation of patients who had mild or no coronary artery disease symptoms and who had been identified by coronary arteriography and left ventriculography to have a type of coronary artery disease which is relatively non-threatening. They were highly selected and meticulously cared for. These factors and the fact that 23% underwent surgery accounts for the low (1.6% per year) mortality rate. Even so, one subset showed a 50% decrease in 5-year mortality in the surgical group, though the numbers are too small to demonstrate a significant difference.

In this study, the randomized patients represented 6.5% of the patients with coronary artery disease in the registry. The correct conclusion from this subset, that there was no difference in survival between medically and surgically treated patients, should not be applied broadly to other mildly symptomatic patients who have not had such complete evaluation including coronary arteriography and who may be in a much higher risk category. Mild symptoms frequently do not indicate mild disease and do not necessarily indicate a benign prognosis.

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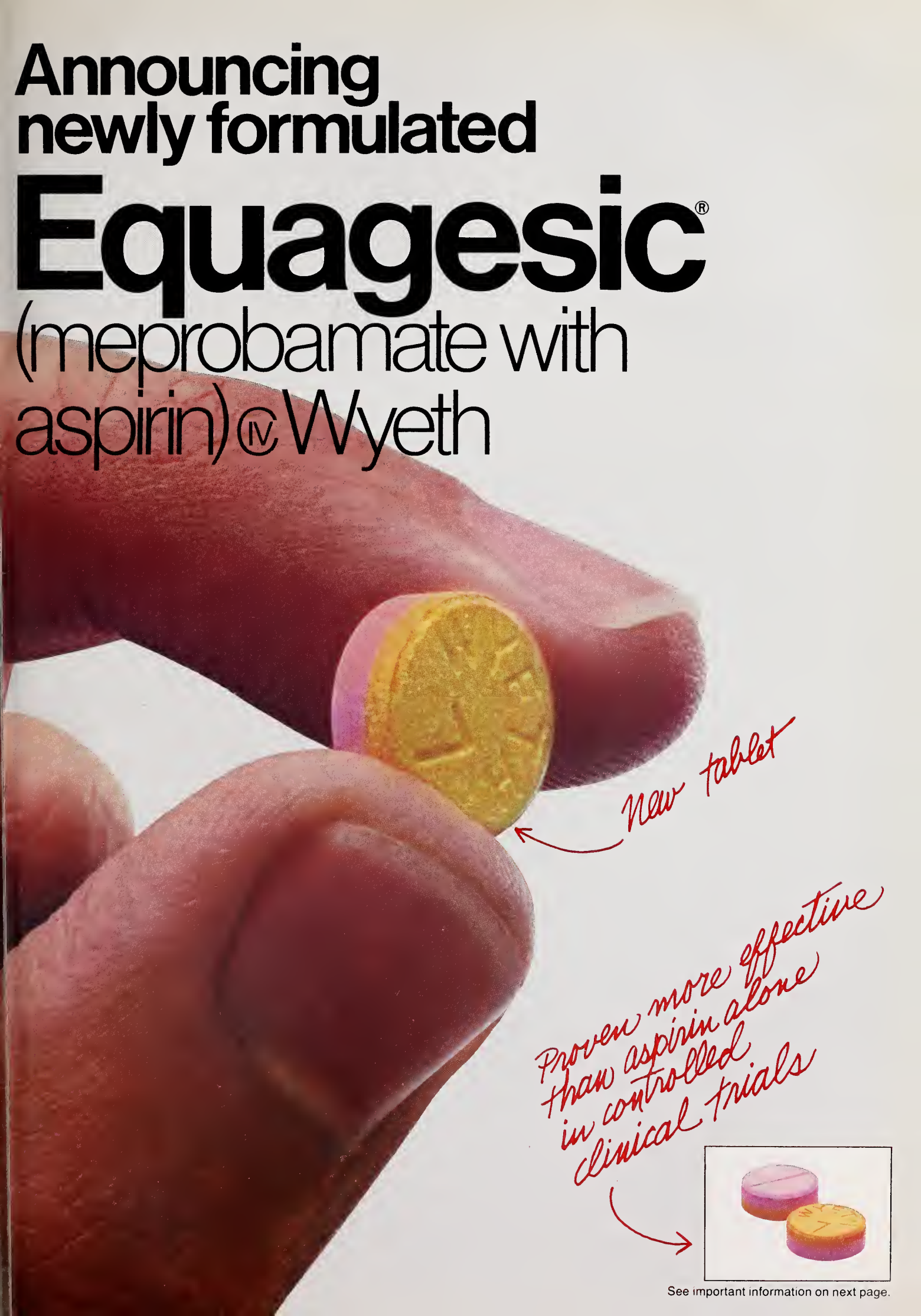
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(BRIEF SUMMARY)

DESCRIPTION:
Each tablet contains 200 mg meprobamate and 325 mg aspirin.

INDICATIONS:
Adjunct in short-term treatment of pain accompanied by tension and/or anxiety in patients with musculoskeletal disease. Clinical trials demonstrated that in these situations relief of pain is somewhat greater than with aspirin alone. Effectiveness in long-term use, i.e. over 4 months, has not been assessed by systematic clinical studies. Physicians should periodically reassess usefulness of drug for individual patients.

CONTRAINDICATIONS:
ASPIRIN: Allergic or idiosyncratic reactions to aspirin or related compounds.

MEPROBAMATE: Acute intermittent porphyria; allergic or idiosyncratic reactions to meprobamate or related compounds, e.g. carisoprodol, mebutamate, or carbromal.

WARNINGS:
ASPIRIN: Use salicylates with extreme caution in patients with peptic ulcer, asthma, coagulation abnormalities, hypoprothrombinemia, vitamin K deficiency, or those on anticoagulants. In rare instances, aspirin in persons allergic to salicylates may result in life-threatening allergic episodes.

MEPROBAMATE: DRUG DEPENDENCE: Physical and psychological dependence, and abuse have occurred. Chronic intoxication from prolonged ingestion of, usually, greater than recommended doses is manifested by ataxia, slurred speech, and vertigo. Therefore, carefully supervise dose and amounts prescribed and avoid prolonged use, especially in alcoholics and others with known propensity for taking excessive quantities of drugs. Sudden withdrawal after prolonged and excessive use may precipitate recurrence of preexisting symptoms, e.g. anxiety, anorexia, or insomnia, or withdrawal reactions, e.g., vomiting, ataxia, tremors, muscle twitching, confusional states, hallucinosis, and, rarely, convulsive seizures. Such seizures are more likely in persons with CNS damage or preexistent or latent convulsive disorders. Onset of withdrawal symptoms occurs usually within 12 to 48 hours after discontinuation; symptoms usually cease within next 12- to 48-hour period. When excessive dosage has continued for weeks or months, reduce dosage gradually over 1 to 2 weeks rather than stop abruptly. Alternatively, a short-acting barbiturate may be substituted, then gradually withdrawn.

POTENTIALLY HAZARDOUS TASKS: Warn patients meprobamate may impair mental or physical abilities required for potentially hazardous tasks, e.g., driving or operating machinery.

ADDITIVE EFFECTS: Since CNS-suppressant effects of meprobamate and alcohol or meprobamate and other psychotropic drugs may be additive, exercise caution with patients taking more than one of these agents simultaneously.

USAGE IN PREGNANCY AND LACTATION:
An increased risk of congenital malformations associated with minor tranquilizers (meprobamate, chlordiazepoxide, and diazepam) during first trimester of pregnancy, has been suggested in several studies. Because use of these drugs is rarely a matter of urgency, their use during this period should almost always be avoided. The possibility that a woman of childbearing potential may be pregnant at time of institution of therapy should be considered. Advise patients if they become pregnant during therapy or intend to become pregnant to communicate with their physician about desirability of discontinuing the drug.

Meprobamate passes the placental barrier. It is present both in umbilical cord blood at or near maximal plasma levels and in breast milk of lactating mothers at concentrations two to four times that of maternal plasma. When use of meprobamate is contemplated in breastfeeding patients, consider the drug's higher concentrations in breast milk as compared to maternal plasma levels.

USAGE IN CHILDREN: Keep preparations with aspirin out of reach of children. Equagesic® (meprobamate with aspirin) is not recommended for patients 12 years of age and under.

PRECAUTIONS:
ASPIRIN: Salicylates antagonize uricosuric activity of probenecid and sulfinpyrazone. Salicylates are reported to enhance hypoglycemic effect of sulfonylurea antidiabetics.

MEPROBAMATE: Use lowest effective dose, particularly in elderly and/or debilitated, to preclude over-sedation. Meprobamate is metabolized in the liver and excreted by the kidney; to avoid excess accumulation exercise caution in its use in patients with compromised liver or kidney function. Meprobamate occasionally may precipitate seizures in epileptic patients. It should be prescribed cautiously and in small quantities to patients with suicidal tendencies.

ADVERSE REACTIONS:
ASPIRIN: May cause epigastric discomfort, nausea, and vomiting. Hypersensitivity reactions, including urticaria, angioneurotic edema, purpura, asthma, and anaphylaxis may rarely occur. Patients receiving large doses of salicylates may develop tinnitus.

MEPROBAMATE: CNS: Drowsiness, ataxia, dizziness, slurred speech, headache, vertigo, weakness, paresthesias, impairment of visual accommodation, euphoria, overstimulation, paradoxical excitement, fast EEG activity.

GI: Nausea, vomiting, diarrhea.

CARDIOVASCULAR: Palpitation, tachycardia, various forms of arrhythmia, transient ECG changes, syncope, hypotensive crisis.

ALLERGIC OR IDIOSYNCRATIC: Milder reactions are characterized by itchy, urticarial, or erythematous maculopapular rash, generalized or confined to the groin. Other reactions include leukopenia, acute nonthrombocytopenic purpura, petechiae, ecchymoses, eosinophilia, peripheral edema, adenopathy, fever, fixed drug eruption with cross-reaction to carisoprodol, and cross-sensitivity between meprobamate/mebutamate and meprobamate/carbromal. Rare, more severe hypersensitivity reactions include hyperpyrexia, chills, angioneurotic edema, bronchospasm, oliguria, and anuria. Also, anaphylaxis, exfoliative dermatitis, stomatitis, and proctitis. Stevens-Johnson syndrome and bullous dermatitis have occurred.

HEMATOLOGIC (SEE ALSO "ALLERGIC OR IDIOSYNCRATIC"): Agranulocytosis, aplastic anemia have been reported, although no causal relationship has been established, and thrombocytopenic purpura.

OTHER: Exacerbation of porphyric symptoms.

DOSAGE AND ADMINISTRATION:
Usual dose is one or two tablets, 3 to 4 times daily as needed for relief of pain when tension or anxiety is present. Not recommended for patients 12 years of age and under.

OVERDOSAGE:
Treatment is essentially symptomatic and supportive. Any drug remaining in the stomach should be removed. Induction of vomiting or gastric lavage may be indicated. Activated charcoal may reduce absorption of both aspirin and meprobamate. Aspirin overdosage produces usual symptoms and signs of salicylate intoxication. Observation and treatment should include management of hyperthermia, specific parenteral electrolyte therapy for ketoacidosis and dehydration, watching for evidence of hemorrhagic manifestations due to hypoprothrombinemia which, if it occurs, usually requires whole-blood transfusions. Suicidal attempts with meprobamate have resulted in drowsiness, lethargy, stupor, ataxia, coma, shock, vasomotor and respiratory collapse. Some suicidal attempts have been fatal. The following data, reported in the literature and from other sources, are not expected to correlate with each case (considering factors such as individual susceptibility and length of time from ingestion to treatment), but represent usual ranges reported. Acute simple overdose (meprobamate alone): Death has been reported with ingestion of as little as 12 grams meprobamate and survival with as much as 40 grams.

BLOOD LEVELS:
0.5-2.0 mg percent represents usual blood-level range of meprobamate after therapeutic doses. The level may occasionally be as high as 3.0 mg percent.

3-10 mg percent usually corresponds to findings of mild-to-moderate symptoms of overdosage, such as stupor or light coma.

10-20 mg percent usually corresponds to deeper coma, requiring more intensive treatment. Some fatalities occur.

At levels greater than 20 mg percent, more fatalities than survivals can be expected.

Acute combined overdose (meprobamate with other psychotropic drugs or alcohol): Since effects can be additive, history of ingestion of a low dose of meprobamate plus any of these compounds (or of a relatively low blood or tissue level) cannot be used as a prognostic indicator.

In cases of excessive doses, sleep ensues rapidly and blood pressure, pulse, and respiratory rates are reduced to basal levels. Any drug remaining in stomach should be removed and symptomatic treatment given. Should respiration or blood pressure become compromised, respiratory assistance, CNS stimulants, and pressor agents should be administered cautiously as indicated. Diuresis, osmotic (mannitol) diuresis, pentoneal dialysis, and hemodialysis have been used successfully in removing both aspirin and meprobamate. Alkalinization of the urine increases excretion of salicylates. Careful monitoring of urinary output is necessary, and caution should be taken to avoid overhydration. Relapse and death, after initial recovery, have been attributed to incomplete gastric emptying and delayed absorption.

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Cancer Treatment in the Community Hospital

JOHN THOMAS WEST, M.D., F.A.C.S., *LaGrange**

THE COMMUNITY hospital holds a key position in the provision of care to cancer patients in the United States. Despite the rising importance of cancer centers in research, teaching, and the development of better methods of treatment, the community hospital is still and will continue to be of great value to most cancer victims. For most cancer patients, the diagnosis is first made at a community hospital. The majority of these patients will receive definitive treatment for cancer at the community hospital, and for many this will be the only cancer treatment they will receive. And even those patients who have their definitive cancer treatment at a cancer center are likely to return for follow-up, rehabilitation, or terminal care to their local community hospital.

The Role of the Community Hospital

The term "community hospital," of course, encompasses a broad spectrum of facilities. Some are very modern and sophisticated in terms of the types of equipment for diagnostic and therapeutic purposes and in terms of the training and expertise of their staff. Some will in fact be able to give virtually the same level of care as could be had at a university medical center. Others will be equipped and staffed only to provide a much simpler level of care. The hospital staff must know what their capabilities and limitations are. And whether a particular community hospital is well or poorly equipped to provide comprehensive care for the cancer patient, the staff should be in touch with the state of the art in cancer care. They should know what is possible and appropriate for the patients they serve. Based on this knowledge, they will know when their patient might be better served elsewhere.

It is altogether fitting that most cancer care is provided at community hospitals. Patients usually prefer to be treated in institutions close to their homes and families, by medical staff with whom they are already acquainted. The cost is likely to be less in a community hospital. And after the primary cancer treatment is given, the patient will likely receive much of the follow-up care locally. This will promote continuity of care, whether the subsequent care be simple follow-up for a patient apparently cured, or rehabilitation for a patient who has experienced severe functional loss, or terminal care for those who will ultimately die of their malignancy.

Some Disadvantages

There may be some disadvantages to cancer treatment at a community hospital. The local hospital may simply not have the requisite diagnostic and therapeutic

* Dr. West practices general surgery. Send reprint requests to him at 301 Medical Drive, Ste. 503, LaGrange, GA 30240.

Prepared at the request of the Georgia Division, American Cancer Society. Others wishing to contribute papers to this Page are invited to send them to Gray T. Fountain, MD, 910 N. Jefferson, Albany, GA 31708.

tools necessary for modern cancer care. Complicated and expensive imaging equipment may be necessary for the proper evaluation of some patients before important decisions can be made regarding therapy. Or some forms of endoscopy may similarly be crucial to a choice of therapy. If these are not locally available, it may be impossible to proceed with treatment until such information is obtained. Such requirements will not be found in every patient, but the physician in charge of the patient's care must determine the patient's needs. When a clear-cut diagnosis of cancer is made, and the extent of the disease is accurately defined, one may in many instances determine that referral to a cancer center would have no important advantages for the patient. Two common examples come to mind: a woman with pre-invasive cancer of the cervix; or a patient with a suspicious breast mass, a negative chest x-ray and no signs, symptoms, or laboratory findings to suggest distant metastases. Such cases can be confidently managed at the community hospital if staff with the requisite surgical skills are present, and if competent anesthesia services are available. A different approach is required if the nature of the process and the extent of the disease are less well-defined. The jaundiced patient with epigastric pain and a suggestion of an upper abdominal mass may require imaging procedures or endoscopy not locally available. It is uncomfortable for the surgeon and unfortunate for the patient when it is first learned at the time of laparotomy that the patient has a malignancy of the bile ducts, for which that surgeon may not be prepared to offer either resection or palliative by-pass.

The skills of an experienced medical oncologist are desirable for the selection and administration of an aggressive multiple-drug chemotherapy regimen for oat cell carcinoma, testicular cancer, or for some ovarian cancers. Lack of these skills at a community hospital may therefore sometimes be reason to refer the patient, or at least to consult with the trained medical oncologist.

Modern, mega-voltage radiotherapy and sources of intracavitary radiotherapy, and the skills to use them, would not be expected to exist in the typical small community hospital. Patients requiring such therapy would naturally be referred to a facility with such capability. Consider the patient with a poorly differentiated cancer of the endometrium, deeply infiltrating into the myometrium. If the hospital in which these facts were established were not able to provide radiotherapy consultation and services, this patient would be better cared for in an institution where such services are available. Referral would be appropriate.

Tumor Registry

Any hospital providing care for cancer patients, whether it be large or small, simple or sophisticated, should have an ongoing evaluation of cancer treatment. A tumor registry is crucial to such a program. The records of a tumor registry will contain information about the kinds of cancer seen at a particular hospital, the frequency of occurrence, the types of treatment rendered, and the results of treatment. From such assessment of cancer treatment, valuable lessons can be learned for improving treatment. For example, a few years ago, using tumor registry information, a study was made of the experience in the treatment of cancer of the colon and rectum at a community hospital[1] and revealed several unexpected and important facts. The post-operative mortality was 16%, most of which occurred 6 or more days after surgery, indicating a need for particular attention to aspects of post-operative management such as fluid and electrolyte balance and respiratory care. It was also noted that sometimes inappropriately radical procedures were carried out for lesions that were early and limited in extent, and which might have been managed by much less aggressive surgical procedure. Appropriate changes in the care of such patients have since been made at that hospital.

The community hospital, however well or poorly equipped it may be for delivering definitive curative care for cancer patients, will continue to be the place where most cancer patients receive their first and their last care. Rehabilitation of survivors and palliative care and hospice programs for those whose cancers are not controlled will be major items of concern for the community hospital. The com-

munity hospital also has a unique opportunity for public education regarding cancer. It is accessible to the local citizens, and its staff know first hand the important cancer problems in that locality. For instance, the hospital tumor registry reveals that cancer of the oral cavity and pharynx is the fifth most common cancer in LaGrange. This tells us that we have an important educational job to do. We must tell our people that "smokeless" is not harmless.

Summary

Community hospitals are a valuable resource for serving cancer patients, and the decisions made at the community hospital may be most important in determining the ultimate outcome for a cancer patient. The staff at a community hospital should be aware of the treatment options for the cancer patients they serve so that they can select those for whom care at the local hospital is possible. Continuing appraisal of the quality of cancer care should occur in all hospitals where such care is given, both cancer centers and community hospitals. A tumor registry is important in such an on-going critique of cancer care. The community hospital will be able to play a vital role in the continuing care of patients who have had primary definitive treatment of their cancer, whether that treatment was administered at a referral center or at the local hospital. The community hospital also has an important role to play in public education regarding cancer.

Reference

1. West JT. Cancer of the colon and rectum: experience at a smalltown community hospital. Texas Med 1975;71:65-71.

Legal Page Notes Continued From Page 250

1. S.B. 186 (creating O.C.G.A. Title 31, Chapter 32). At the time this Legal Page went to press, the Living Will Bill was awaiting signature by Governor Harris.

2. *In re L.H.R.*, Civil Action No. 84-1757-5, DeKalb County Superior Court (February 10, 1984).

3. Pursuant to O.C.G.A. § 31-10-16(a), a person may be pronounced dead by a qualified physician if it is determined that the individual has sustained "irreversible cessation of *all* functions of the entire brain, including the brain stem." (Emphasis supplied.)

4. The Court appointed a guardian ad litem for L.H.R. and ordered an "independent evaluation" by the guardian, so that the Court would be assured that "neither the medical community nor L.H.R.'s parents had any interest adverse to L.H.R."

5. *Young v. Emory University*, Civil Action No. 83-6143-5, DeKalb County Superior Court (August, 1983).

6. *Matter of Quinlan*, 355 A.2d 647 (S.Ct.N.J. 1976).

7. See, e.g., *Superintendent of Belchertown State School v. Saikewicz*, 370 N.E.2d 417 (S.Ct.Mass. 1977); *Matter of Bertha Colyer*, 660 P.2d 783 (S.Ct.Wash. 1983).

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10. Standards Committee of the Skin Council of the American Association of Tissue Banks. Guidelines for the banking of skin tissues. American Association of Tissue Banks Newsletter 1979;3(1):5-8.

11. Official Code of Georgia Annotated 1983; Volume 31, Title 44, Article 6, Section 44-5-140 to 44-5-148.

12. May SR, DeClement FA. Skin banking methodology: An evaluation of package format, cooling and warming rates, and storage efficiency. Cryobiology 1980;17:34-45.

13. Blondet R, Gilbert-Thevenin MA, Pierre C, Ehrsam A. Skin preservation by programmed freezing. Br J Plast Surg 1982;35:530-536.

14. May SR, Guttman RM, DeClement FA. Simplified skin cryopreservation using an insulated heat sink box. Cryobiology 1983;20:744.

president's letter



Fitness Report

While agonizing about how to summarize the events of the past 11 months, the words "fitness report" erupted up from my memories of time spent with the Naval forces. Like it or not, we need a fitness report from time to time to serve as a bench mark, to goad us toward improvement, and to satisfy us regarding specific achievements.

I think we have had a fair balance during the past year: the good things we have accomplished are balanced by problems that were met poorly or are yet unsolved.

To our credit, I honestly feel that Operation Care, our Legislative Conference at Amelia Island, the Medical-Legal Seminar, the Leadership Conference, the results obtained during the recent session of the Georgia Legislature, and our action regarding the voluntary freezing of physicians' fees for one year constitute genuinely good marks. My heart is filled with appreciation and warm feelings for the many, many people within our staff and among our colleagues whose time and efforts brought these things to fruition.

Additional good marks are deserved for our Scientific Assembly and other efforts in the field of continuing medical education; for the improved avenues of communication between ourselves and a variety of state agencies; and for the work done by the Maternal and Infant Health Committee and Task Force and the exciting program about to begin in an effort to impact on the related problems of teenage pregnancy and infant mortality. The reorganization of our committee system and the continuing improvement in our communications with our membership through the MAG *Newsletter* and *Journal* deserve recognition.

There is, however, another side of the coin. We have problems that to date have been poorly. inadequately or not yet met. I cannot help but feel a sense of inadequacy, frustration, and disappointment that I have to leave these problems to my successor, Bill Clark, to work toward their ultimate solution. The overriding problem is that of bringing back together our MAG family which includes ourselves, GaMPAC, MAG Mutual, and the Georgia Medical Care Foundation. In the order mentioned, we have failed to support GaMPAC honorably and to a degree that would allow it to function adequately on our behalf. The percentage of our membership giving either minimal or meaningful financial support is pitiful. When viewed against their accomplishments despite limited means, I think we have to make a strong case for child neglect. The MAG Mutual situation is entirely different. We have given it exceptionally good support. It has flourished and, indeed, to the point of outgrowing our ability to sustain its growth and development. To the degree to which we were unable to predict and plan for the sustenance of this burgeoning growth, we have been likewise negligent, but perhaps the apex of our deficiencies lies in our relationships with the Foundation. Here is an organization that we founded to insure that doctors, not clerks and bureaucrats, would direct the medical review process. We have not only been unable to provide adequate support but we also have evolved into a frustrating situation of having to possibly support a further separation rather than a coming together of our organization in order to keep it functional and competitive.

All told, I have had a serious foreboding of this process of separation of our family and a very strong desire to reverse that process and to bring our family together spiritually, physically, and financially.

To that end, we undertook the painful process of reviewing our association operations and made the decision that we needed and would get a higher level of administrative efficiency and function and that we would seek as much as possible to correct and improve those aspects of our operations that have contributed to these problems.

There are additional problems related to those noted above. One that I am sure will occupy a major segment of our Annual Session is the financing of our organization and the dues structure. We have been 7 years without a dues increase, and times have changed considerably in that period. There will necessarily be many differing viewpoints to be considered in hammering out a satisfactory answer.

Our endorsed membership insurance program, which I consider to be the finest available for physicians in the country, is threatened, I believe, by a proposal to remove exclusive endorsement and to endorse multiple insurance schemes as they come along. I have serious concerns about the maintenance of credibility and value of our endorsement and more serious concerns about the effect on participation and the continuing enlistment of our newer and younger members in the program that is so essential to the continued maintenance of a strong and progressive program. We went through the

(Continued on page 264)

NEW MEMBERS

Anastasiades, Dinos M., MAA—I&R
3922 W. Wood Path, Stone Mountain 30083

Arunachalam, Krishnan, Coffee—ACT—IM
P.O. Box 1489, Douglas 31533

Brown, Samuel B., MAA—ACT—P/N
450 E. Paces Ferry, NE, Atlanta 30305

Burroughs, Fleming, Sumter—ACT—IM
715 N. Lee St., Americus 31709

Busbee, Perry G., Jr., Bibb—I&R
Medical Center of Central Georgia, Macon 31204

Chapman, Rodger W., MAA—ACT—EM/IM
340 Boulevard, NE, Ste. 135, Atlanta 30312

Chhokar, Balbir S., Muscogee—ACT (N-1)—OPH
309 Doctors Bldg., 711 Center St., Columbus 31901

Connell, Don R., Ogeechee River—ACT (N-1)—R
500 E. Grady St., Statesboro 30458

Easley, Paul E., Hall—ACT (N-2)—AN
Lanier Park Anesthesia, P.O. Box 2979, Gainesville 30503

Escondo, Gerson Z., Muscogee—ACT (N-2)—P
Doctors Bldg., Ste. 220, Columbus 31907

Estes, Thomas L., Colquitt—ACT (N-2)—GS
3004 Second St., SE, Moultrie 31768

Gayton, Johnny L., Peachbelt—ACT (N-2)—OPH
216 Corder Rd., Warner Robins 31093

Gill, Surinder P. S., Lumpkin—ACT—R
Lumpkin County Hospital, Dahlonega 30533

Harvey, John S., MAA—ACT (N-2)—GS
993 Johnson Ferry Rd., Ste. 200-F, Atlanta 30342

Howard, Leonard F., Thomas Area—ACT (N-2)—FP
Doctors Park, Cairo 31728

Jerkins, Gregory L., MAA—I&R
300 Boulevard, NE, Atlanta 30312

Johnson, Joe H., Bibb—I&R—GS
Medical Center of Central Georgia, Macon 31210

Kelley, Terry V., Bibb—I&R
Medical Center of Central Georgia, Box 70, Macon 31208

Khouri, Joseph, Cobb—ACT—EM
2491 Paces Ferry Rd., Smyrna 30080

Kolla, Iris S., MAA—I&R
1131 Rogers St., Clarkston 30021

Lazo, Rodolfo S., Baldwin—ACT—GS
Central State Hospital, Milledgeville 31062

Larrauri, Manuel S., Baldwin—ACT—P
Central State Hospital, Milledgeville 31061

Lynn, Ronald B., Floyd-Polk-Chattooga—ACT—N
321 Turner McCall Blvd., Rome 30161

Maples, Russell V., Spalding—ACT (N2)—IM/PUD
231 Graefe St., Griffin 30223

Mayo-Rojas, Henry, Muscogee—ACT (N-2)—CD/IM
St. Francis Medical Park, Ste. 203, Bldg. G, 2300 Manchester Exwy., Columbus 31904

Miller, William C., Jr., Bibb—I&R—GS
Dept. of Surgery, Medical Center of Central Georgia, Macon 31204

Miron, Edward J., Gordon—ACT (N-2)—FP
9 Hospital Dr., P.O. Box 125, Calhoun 30701

Morrow, Richard C., Carroll-Haralson—ACT—U
Groover Medical Bldg., Carrollton 30117

Newton, William B., Walton—ACT—P/CHP
333 Alcova St., Monroe 30655

O'Barr, Thomas B., MAA—I&R
184 Westminster Dr., NE, Atlanta 30309

Oettinger, Carl W., MAA—ACT—IM/NEP
25 Prescott St., Ste. 6426, Atlanta 30308

Palmer, SuzAnne J., Baldwin—ACT (N-2)—OBG
P.O. Box 489, Milledgeville 31061

Patel, Sumani G., Spalding—ACT (N-2)—IM
691 S. Eighth St., Griffin 30223

Patton, John W., MAA—ACT—AN
P.O. Box 28637, Atlanta 30358

Putnam, James R., MAA—ACT (N-2)—OS/OPH
Ste. 3401, 25 Prescott St., Atlanta 30308

Rodriguez, Adriana, Glynn—ACT (N-2)—R
3010 Hampton Dr., Brunswick 31520

Rodriguez, Martin, MAA—ACT—GP/IND
4830 Fulton Industrial Blvd., Atlanta 30336

Rollins, Luther C., MAA—ACT—GS
35 Collier Rd., Ste. 470, Atlanta 30309

Rushton, Henry G., Jr., Cobb—ACT (N-2)—U
660 Cherokee St., Marietta 30060

Schwartz, Fred J., MAA—ACT—AN
35 Collier Rd., Ste. 560, Atlanta 30309

Shirazi, Smed H., MAA ACT—IM/CD
Ste. 103, 4555 N. Shallowford Rd., Atlanta 30338

Smith, Robert E., Floyd-Polk-Chattooga—ACT—FP
302 Turner McCall Blvd., Rome 30161

Suarez, Ramon A., MAA—ACT (N-1)—OBG
105 Collier Rd., Ste. 2030, Atlanta 30309

Taylor, Charles D., Hall—ACT—IM
710 Broad St., SE, Gainesville 30501

Thigpin, Corbett M., Richmond—ACT (N-2)—ORS
Humana Medical Plaza, #210, Augusta 30909

Von der Lage, Frederick C., Jr., MAA—ACT—AN
25 Prescott St., Ste. 6426, Atlanta 30308

Wood, Mark G., Thomas Area—ACT (N-2)—NEP
114 Mimosa Dr., Thomasville 31792

Zloczover, Gerardo, Clayton-Fayette—ACT—AN
Bldg. A, 409 Arrowhead Blvd., Jonesboro 30236

PERSONALS

Fifth District

Emory University received a 1 million dollar endowment to fund a professorship in the name of **Carter Smith, Sr., M.D.,** an Atlanta internist and cardiologist. Dr. Smith, a 1926 graduate of Emory University School of Medicine, joined the Piedmont Hospital medical staff in 1931.

Working as part of Reproductive Biology Associates, **Joe B. Massey, M.D.,** and **Hilton I. Kort, M.D.,** Atlanta obstetrician/gynecologists, achieved two successful pregnancies through in vitro fertilization in each of its first two treatment cycles of patients. Approximately 300 in vitro pregnancies have occurred since 1978 and fewer than 100 of them in the U.S. Reproductive Biology Associates, founded September 1, 1983, is the first outpatient in vitro program in the Southeast.

Sixth District

Kenneth Harper, M.D., a general surgeon from Macon, will open a practice in Elberton in July.

Seventh District

Michael J. McCoy, M.D., formerly of Stone Mountain, has opened an office in Lilburn for the practice of obstetrics and gynecology.

Eighth District

James A. Campbell, M.D., of Fitzgerald, has opened his practice of general medicine in Ashburn.

Arvind M. Patel, M.D., was named a Fellow of the American College of Surgeons.

Brunswick pediatrician, **Roy F. Thagard, M.D.,** announced the closing of his practice of 27 years. Dr. Thagard has taken on full-time duties in his position as Addictive Disease Program Director for Charter By-the-Sea Hospital.

SOCIETIES

William J. Rawls, M.D., Decatur cardiologist, was installed as president of the **DeKalb Medical Society** at its recent annual meeting. Other officers of the medical society's board are: Clyde B. Rountree, M.D., President-elect; Nicholas M. Bath, M.D., Vice President; and Roy W. Vandiver, M.D., Secretary-Treasurer.

DEATHS

Stanley D. Aldridge

Stanley D. Aldridge, M.D., chairman of the DeKalb County Board of Health, died January 12 at age 61. Dr. Aldridge was past president of the DeKalb Medical Society and was a member of the American College of Physicians, the American and Georgia Societies of Internal Medicine, and the American College of Clinical Pharmacology. He graduated from the Medical College of Georgia.

Dr. Aldridge is survived by his wife, two daughters, and two brothers.

Loree Florence

Loree Florence, M.D., 87, died September 24, 1983. She was the first female graduate from the Medical College of Georgia.

Dr. Lawrence was also the first woman on the charter chapter of Alpha Omega Alpha.

Dr. Lawrence is survived by one nephew.

John Morgan Kellum

John Morgan Kellum, M.D., Thomaston physician, died in January. He was 73. A graduate of Emory University School of Medicine, Dr. Kellum was a member of the Southern Medical Association, the American College of Surgeons, and the Georgia Surgical Society.

Survivors include his wife, three sons, two sisters, one brother, and four grandchildren.

Edgar J. Maxwell, Jr.

Edgar J. Maxwell, Jr., M.D., 64, died January 15. Dr. Maxwell was a graduate of the Medical College of Georgia. He was Chief of Surgery, Station Hospital in Labrador and Newfoundland for the U.S. Army from April 1946 to December 1947. He was a member of the American Academy of Family Practice and the Southern Medical Association.

Dr. Maxwell is survived by his wife, one daughter, one foster daughter, two sons, four sisters, and two brothers.

Committee Activities . . .

Highlights — February, 1984, MAG Executive Committee Meeting

Committee on Legislation:

1) *Living Will* — The Executive Committee voted MAG's support of the concept of "Living Wills" as expressed in S.B. 186.

2) *H.B. No. 1296-Indigent Care of Labor Patients* — Discussion ensued regarding H.B. 1296 pertaining to the protection of indigent and elderly patients. (Ga. Code 31-8). The bill requests "certain hospitals to provide emergency medical services to pregnant women in labor" and that counties of residence pay for this specific emergency service if it is provided to an indigent patient. It was pointed out that the bill also provides that no physician, hospital (or its agent), or employees shall be guilty of malpractice or civilly liable unless proven grossly negligent in providing health care. The Executive Committee accepted the report on this bill as information.

3) *Informed Consent-Breast Cancer* — MAG legal counsel was asked to draft a substitute bill which would result in the provision of adequate information to a patient found with breast cancer and its treatment. The proposed bill requires the Composite Board of State Medical Examiners to publish an informational booklet — when funds are appropriated for such purposes. Following discussion, the Executive Committee approved this bill as drafted.

4) *PIP Program* — Dr. Kaufmann reported that the PIP Program was honored to have a large group of physicians and wives from Macon at the General Assembly this past week. He asked that other county medical societies be contacted to get more groups of this nature to attend the legislature.

Membership Committee

Practice Management Seminar for Residents — The Membership Committee presented a proposal to the Executive Committee regarding Practice Productivity, Inc., conducting a seminar for senior residents on "How to Establish a Successful Practice," with MAG as a co-sponsor and no financial obligations. The Executive Committee agreed to co-sponsor the Practice Productivity seminar for residents with the stipulation that:

—MAG approves the program content and all publicity pieces which mention the MAG or use our logo;
—MAG staff will attend the seminar and determine whether future PPI seminars should be co-sponsored by the MAG;
—MAG staff will prepare, distribute, and collect evaluation forms for the seminar attendees.

The Executive Committee emphasized that this should not be considered as an MAG endorsement of Practice Productivity, Inc., as a medical practice management firm.

DHR Board Members — The December Executive Committee voted to invite DHR Board members to meet with the Executive Committee in February to discuss ways and means by which MAG might help the physician members in their dealings with DHR matters. Four of the five physician members of the DHR Board attended. They each emphasized the need for input from MAG on the broad range of DHR actions which directly affect the practice of medicine in Georgia. It was agreed the MAG staff needed to be informally involved as much as possible in the development of proposals before they reach the DHR Committees chaired by the physician members of the Board.

GTE Minet — Update and Plan for Marketing:

MAG Committee on Computer Education — In order to oversee these activities, the Executive Committee formed an MAG Committee on Computer Education with the following charge:

> "The Committee will oversee the Association's marketing activities for the AMA/GTE Medical Information Network; and as part of those activities will conduct programs to educate physicians on the applications of computers in the medical office."

MAG Membership Benefits-Computer Vendors — It was brought to the attention of the Executive Committee that the action taken in November endorsing six computer vendors conflicted with the proposed educational concept of the Committee on Computer Education. The Executive Committee therefore rescinded the action of the November 20 Executive Committee which had approved the Membership Committee's benefit package endorsement of six computer vendors.

Ad Hoc Committee on Operations' Screening Committee:

The Screening Committee for the selection of an MAG Executive Director is receiving applications and expects to make a selection by April 25.

Medical Aspects of Sports Committee Letter:

Dr. Moore received a letter from Letha Hunter, M.D., Chairman of the Medical Aspects of Sports Committee, requesting MAG approval for the committee to send a newsletter to the high school coaches around the state. It was reported that funds for this has been included in the 1984-1985 budget request for the Medical Aspects of Sports Committee. No further action was taken.

AMA Council on Scientific Affairs:

On motion, the Executive Committee approved the nomination of Ellis B. Keener, M.D., Gainesville, to the AMA Council on Scientific Affairs. It was understood by the Executive Committee that if a campaign is requested, MAG would proceed with limited fiscal support.

Southern Medical Insurance Retirement Committee:

Dr. Moore reported that the Southern Medical Insurance Retirement Committee has made a number of improvements to SMA's total insurance package.

Grady Hospital/Morehouse:

Louis Sullivan, M.D., President and Dean of Morehouse School of Medicine, requested MAG support in gaining access to Grady Hospital teaching programs to provide clinical experience for Morehouse medical students. Dr. Sullivan stated that some opposition had been expressed by some of the faculty at Emory School of

Medicine. He felt the opposition was due to a misunderstanding of what Morehouse would expect. Following discussion, the Executive Committee expressed support of the philosophy that Morehouse students, through a cooperative arrangement with Emory, have access to clinical training at Grady.

Appointment to Third Party Relations Committee:
On motion, the Executive Committee appointed Julia V. Ashley, M.D., as a member of the Committee on Third Party Relations, effective immediately. Dr. Ashley has agreed to serve in this capacity.

MAG Committee Appointments:
The Executive Committee considered the MAG Committee appointments and requested staff to mail to the Executive Committee a complete listing of the committees for their recommendations.

AMA Nominations:
The Executive Committee approved the following nominees of the Georgia Society of Otolaryngology to serve as MAG's recommendations for various AMA committee appointments. Other specialty society input was requested.

—John D. Harman, M.D., Medical College of Georgia to serve on Otolaryngology Residency Review Committee;
—John S. Turner, Jr., M.D., Emory University Clinic, Atlanta, to serve on Otolaryngology Residency Review Committee and/or Graduate Medical Education Advisory Committee;
—John Burson, M.D., Carrollton, to serve on Otolaryngology Residency Review Committee.

Gwinnett County Medical Society Delegate:
On motion, the Executive Committee added another delegate from the Gwinnett County Medical Society as a delegate to the MAG House of Delegates.

For Information Only:
The following items were brought to the attention of the Executive Committee for information only:

A. A letter from Aaron J. Johnson, DMA Commissioner, stating the Governor's Fiscal Year 1985 Budget includes funds for health services for 1,500 pregnant women and almost 11,000 children annually, projecting the state health benefits cost for this program, $1,267,839, and expressing appreciation for MAG's support in this matter.

B. A report of the recommendations of the NMR Advisory Committee to the Georgia Statewide Health Coordinating Council was presented. It was pointed out that this report contains the current guidelines for placement of NMR devices. These guidelines specifically recommend that placement should be allowed at Emory University Hospital and a hospital designated by the Medical College.

Discussion ensued comparing the development of NMR with the development of CT scanning and the likelihood of decreased costs for the NMR equipment. The Executive Committee agreed to urge SHPDA to conduct frequent and ongoing evaluation of these developments.

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Occupational physicians: Full-time position at 4,000 employee assembly plant in Georgia. The physician will be responsible for directing both the clinical and administrative aspects of the entire plant medical program. Growth opportunities to the corporate level are available to the successful physician who is able to combine proficiency in the medical field with sound management techniques. Previous industrial experience is desirable but not required. Salary is competitive plus an outstanding fringe benefit program. For further information, contact R. P. Surowiec, Personnel Director, GMAD, Lakewood, Atlanta, GA 30315; (404) 624-2624.

Psychiatrist: Georgia-St. Simons Island — General psychiatrist with inpatient experience to work with expanding group practice. High starting salary. Resort area with growing population. New 60-bed hospital. Reply to Box 4-B c/o *Journal*.

Physician needed to lease fully-equipped clinic in downtown Atlanta (Edgewood Emergency Clinic). Near Grady Hospital and GA. State University. Private or industrial practice. Call (404) 525-4865.

Retired or semi-retired family practice or internist to help with week-day and weekend work in my office and in the hospital. Send CV to: Occupant, 8115 S.W. 1st Place, Gainesville, FL 32605.

FOR RENT

Ideal Practice Location — Choice office suite in a new attractive professional building. Close to new Gwinnett Hospital, between Gwinnett Place and Lake Lanier. Highly visible on main thoroughfare. (404) 945-3010.

Sublease Physician's Suite: Two consultation offices, 2 exam rooms, separate bathroom, and business office. Total of 972 sq. ft. Located in Northwest Medical Center, adjacent to West Paces Ferry Hospital. If interested contact: Janice Latoza at (404) 522-3766.

12,000 sq. ft. Medical-Dental Building. Jimmy Carter Blvd. between Green's Corner and I-85. Space available June, 1984. Now leasing. Call (404) 939-8500.

Modern 1300 sq. ft. medical office suite near Kennestone Hospital, Marietta. Call (404) 422-4555.

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POSITION AVAILABLE

Executive Director, Medical Association of Georgia — The Medical Association of Georgia, with 5300 members and headquarters in Atlanta, invites applications for the position of Executive Director. The Executive Director serves as the administrative official of the Association, supervises its staff and is responsible for the overall operation of its activities. Qualifications shall include managerial experience, MBA equivalency, and computer literacy. Salary will be commensurate with experience. Position will be filled April 25, 1984. Submit resume to: W. W. Moore, Jr., M.D., President, 25 Prescott Street, NE, Ste. 4439, Atlanta, Georgia 30308. The Medical Association of Georgia is an Equal Opportunity Employer.

POSITION WANTED

Cardiologist — Recent graduate; board eligible, presently practicing but desires location in Southeast; catheterization and coronary angioplasty plus noninvasive skills. Reply to Box 4-A, c/o *Journal*.

SERVICES

1984 CME Cruise/Conferences on Legal-Medical Issues — Caribbean, Mexico, Hawaiian, Alaskan, Mediterranean, 7-14 days in Winter, Spring, Summer. Approved for 18-24 CME Cat. 1 credits (AMA/PRA). Distinguished professors. Fly roundtrip free on Caribbean, Mexican, and Alaskan cruises. Excellent group fares on finest ships. Registration limited. Pre-scheduled in compliance with present IRS requirements. Information: International Conferences, 189 Lodge Ave., Huntington Station, NY 11746. (516) 549-0869.

Atlanta Medical Forum — On-line computer bulletin board for physicians and others interested in computers and medicine. Call (404) 351-9757 (Free access).

Professional Seminars — Hilton Head Island, SC: On-going seminars at your convenience weekly, Monday-Friday. Continuing education while vacationing on beautiful resort island. Reduced accommodations available. For information, write: Carolina Seaside Seminars, P.O. Box 3013, Hilton Head Island, SC 29928. Call: (803) 842-5546.

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President's Letter

(Continued from page 258)

embarrassment and difficulties of a failing insurance program in the mid 1970s, and I certainly hope that we will not let ourselves get into that position again.

Regarding membership, there are between 7,000 and 9,000 physicians in Georgia licensed to practice, and 5,600 of these are MAG members. We need continued and expanding efforts to gain the participation and support of those non-members who benefit from MAG without contributing to our efforts.

By the time this article is published, I am hopeful that we will have chosen and installed a new Executive Director and that we will have made significant progress in accommodating the needs of the Foundation to function in a rapidly changing climate of medical review needs.

I am very grateful for the hard work of our staff, our committees, our members, and our auxiliary that have kept our fitness report in some semblance of balance. I would earnestly ask you to recognize the problems of the Association and to redouble your efforts to help Bill Clark and your other officers to deal with these problems during the coming year.

Thank you for 1983-84. You have given me a great present, and I very much appreciate it.

William W. Moore, Jr., M.D.

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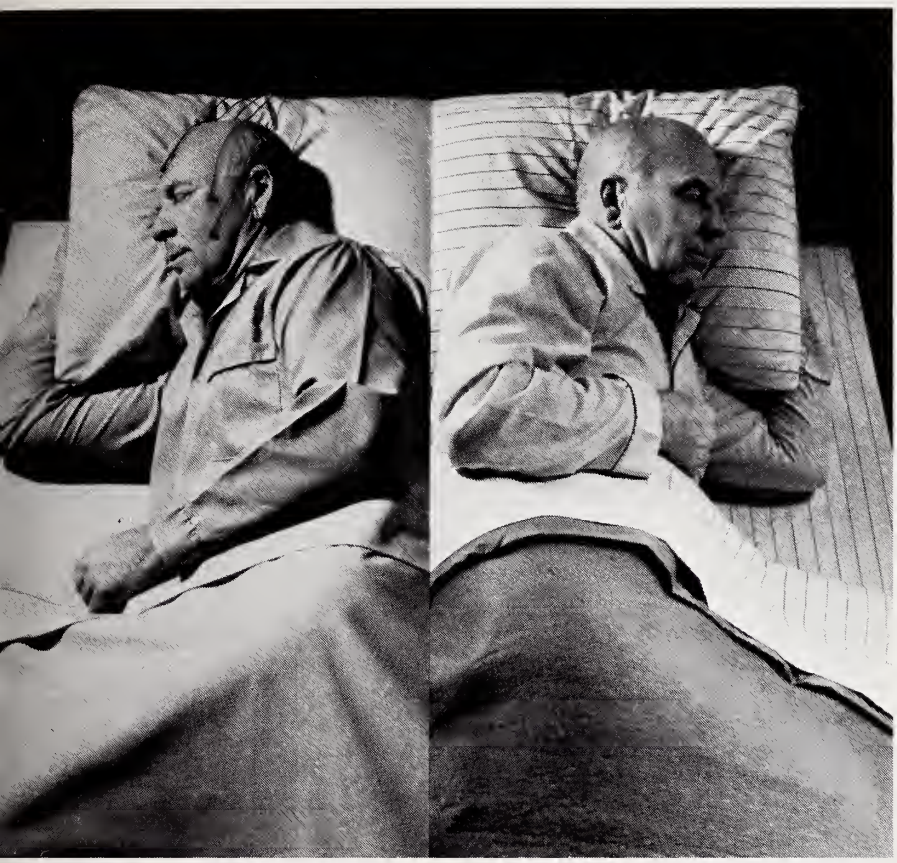
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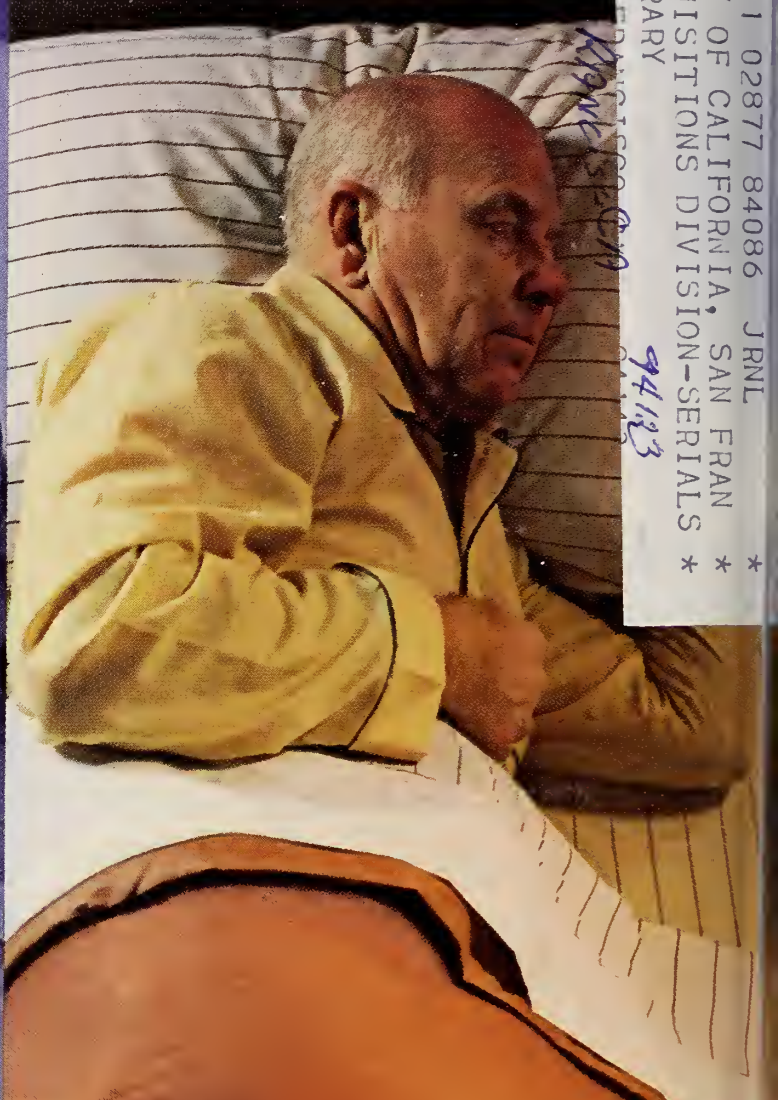
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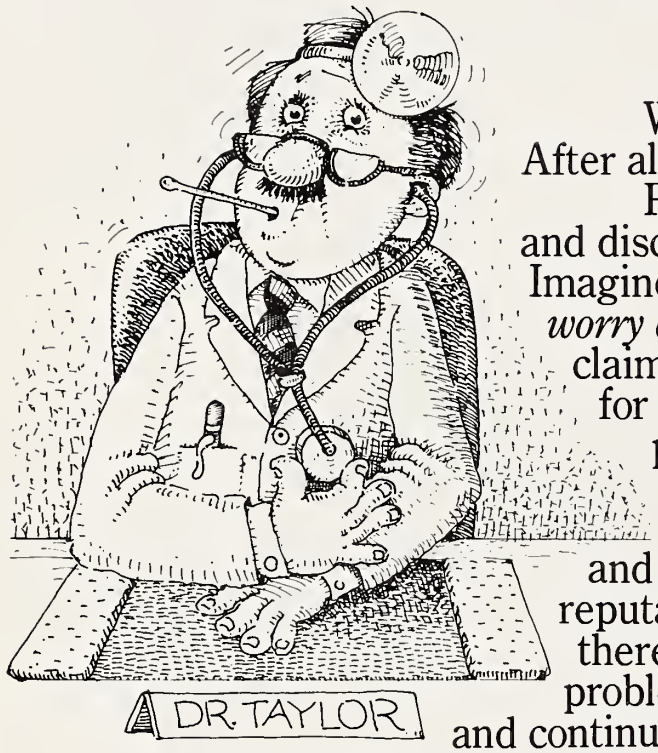
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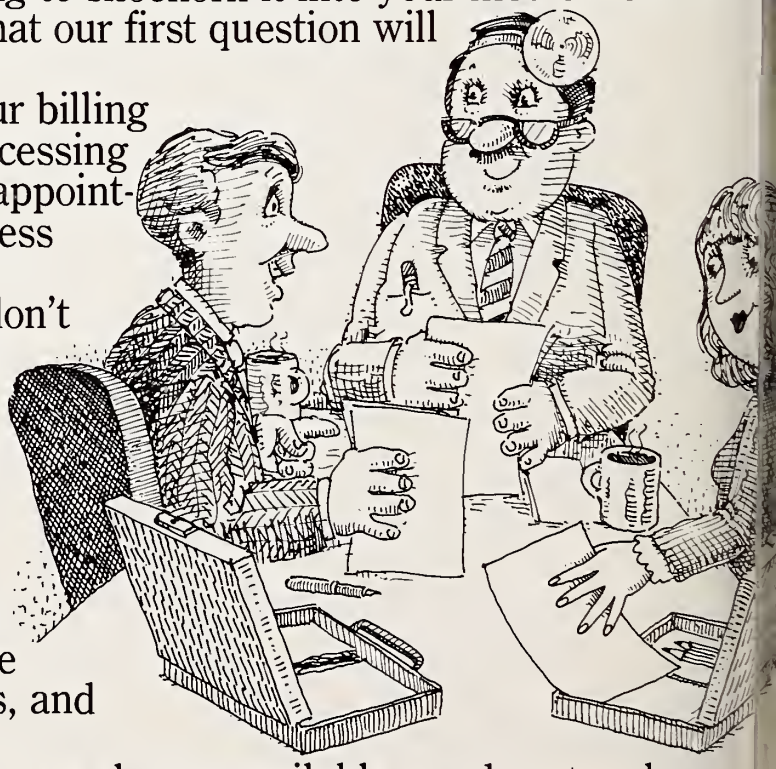
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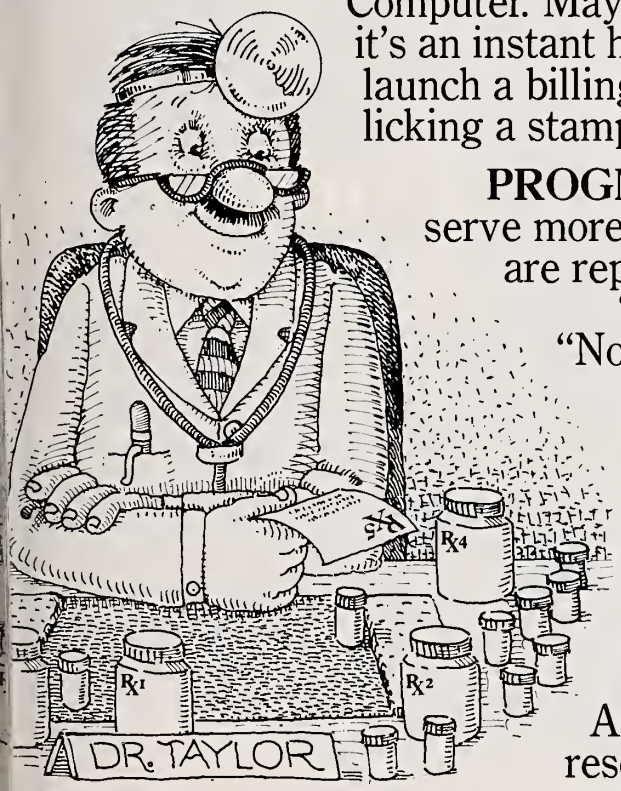


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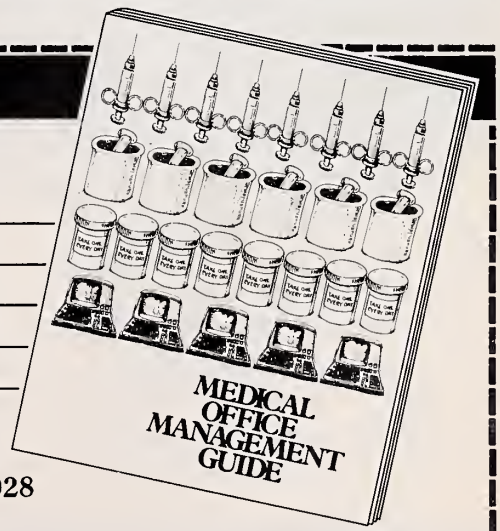
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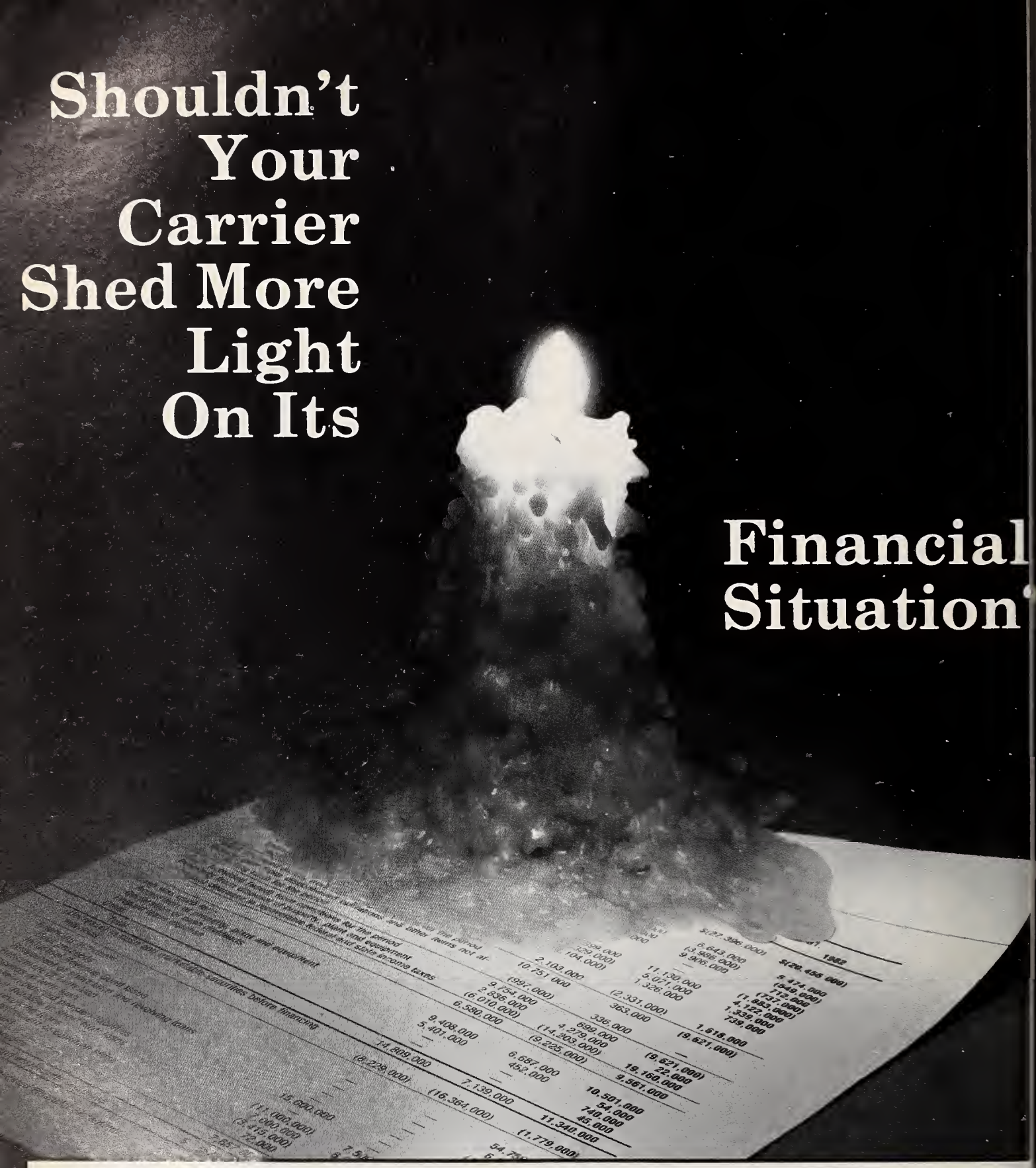


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The subscription price per year for members of the Medical Association of Georgia is $7.50, included in the annual membership dues. The subscription price for nonmembers is $15.00 in the United States, Canada and Mexico, and $17.00 in other countries. Single copies are $2.

The *Journal of the Medical Association of Georgia* is published monthly at 938 Peachtree Street, N. E., Atlanta, GA 30309-3990. Second-class postage paid at Atlanta, Georgia, and at additional mailing offices. POSTMASTER: Send address changes to Medical Association of Georgia, 938 Peachtree Street, N. E., Atlanta, GA 30309-3990.

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THE COVER

The Community Care for the Elderly Act is a significant piece of legislation that can help us better care for our elderly patients. Dr. Okel's article on page 281 and Dr. Woody's editorial on page 309 address this issue.

This month's cover illustration is by Eddie Reddick who is with Publications and Productions, Georgia Department of Human Resources; cover design by Richard Lyons of Richard Heiman Advertising, Inc.

Incidental Intelligence . . .

Medicare Reform Movement Grows

Next year, Medicare spending for physician services will "become the third largest federal domestic program — exceeded only by Social Security and the Medicare hospital insurance program," according to a study for the Senate Committee on Aging.

About one-third of all Medicare expenditures — nearly $25 billion — will go for physician care and spending on the supplemental medical insurance (SMI) side of the program is expected to increase by 16.1% in 1984. If the projection holds up, SMI will be the "fastest growing of the major domestic programs."

These statistics are likely to be cited again and again in the months and years ahead as Congress struggles to reduce the federal deficit, put Medicare's hospital fund back on sound financial footing, and determine whether the program's prospective hospital pricing system should be extended to physicians.

In 1985, Medicare spending for physician services will become the third largest federal domestic program. . . .

On March 16, they were the backdrop for discussion of a wide range of potential changes in Medicare physician reimbursement offered primarily by academicians and groups representing the elderly. Chaired by Sen. John Heinz (R-PA), the discussion centered primarily on suggestions that Medicare move to negotiated fee schedules or extend the hospital diagnosis related groups (DRGs) to physicians.

The only representative of organized medicine to testify at the hearing — AMA Board member James S. Todd, MD — reported that the AMA has asked physicians to voluntarily freeze fees for all patients. The New Jersey surgeon argued that a physician DRG system "would give substantial economic incentives to provide minimal care" and observed that current policies of the Federal Trade Commission appear to mitigate against the use of negotiated fee schedules.

The committee paper, written by former office of Management and Budget health official Lyn Etheridge, contends that current Medicare reimbursement policies have "created unintended inequities among primary care physicians and specialists, inpatient and outpatient care, urban and rural areas."

In addition, Etheridge believes Medicare's current customary, prevailing, and reasonable payment mechanisms has "distorted incentives for appropriate medical care" by encouraging hospitalization and surgery and the adoption of "add-on technology." He notes that the number of procedures that can be separately billed to Medicare has tripled since the program's inception and that the number of bills submitted by physicians increased by about 220% in the 1970s.

Since Medicare will constitute about 18% of the average physician's income in 1985 and since the physician supply in the United States has risen by 70% since Medicare's inception, Etheridge concludes that reform of Medicare's physician payment system is possible and might be accompanied by "improvements" in the claims assignment process.

One option examined by Etheridge was the use of negotiated fee schedules — an approach that is being tried in the Massachusetts Medicaid program and that was endorsed in the Social Security Advisory Council's recommendations for Medicare. The negotiated fee approach is also favored by Princeton economist Uwe Reinhardt, PhD, who told the committee that any "workable reform must be structured around the preservation of the fee-for-service approach."

A researcher with the University of North Carolina, however, said he thinks it will be "difficult if not impossible for the government to control physician costs under the current fee-for-service reimbursement system." Thomas Rice cited his study of Denver physician reactions to a decline in Medicare reimbursement rates in 1977 as evidence that freezing physician reimbursement "is not effective" because physicians will "recoup lost income" by billing for "a greater number of services and for more highly-complex and costly" procedures.

In questioning, Sen. Heinz used Rice's predictions to suggest to Dr. Todd that the AMA, in addition to asking physicians to freeze fees, should recommend that volume be held to its current level. Todd "rejected the concept that physicians will raise the volume of services to get around a freeze" and pointed out that AMA policy already makes it "clearly unethical" to increase volume by providing unnecessary services. Todd said that increased volume could in fact occur for quite legitimate reasons — including an increase in elderly patients and improved technology.

. . . the number of procedures that can be separately billed to Medicare has tripled since the program's inception and . . . the number of bills submitted by physicians increased by about 220% in the 1970s.

Todd also noted that much of the increase in claims volume cited in the Etheridge paper may stem from a shift from inpatient to outpatient care that could save Medicare money. Furthermore, he reported, FTC and Justice Department actions involving relative value scales have stymied the use of RVS and fee schedules by physicians.

At the same hearing, representatives of the National Council of Senior Citizens and American Association of Retired Persons (AARP) called for mandatory assignment of physicians claims for inpatient services.

In 1980, aged beneficiaries' liability from unassigned claims exceeded $1.3 billion or about 13% of total physicians' charges for the elderly that year, AARP President-elect Vita Ostrander told the committee. Beneficiaries now pay over "60% of the cost of physician care out of

pocket,'' she added, and there is new evidence to show that some can no longer afford private insurance to supplement Medicare.

Ostrander added that ''plans simply calling for participating physician agreements offer no assurance against a decline in the overall assignment acceptance rate.'' She called for adoption of a House proposal requiring the hospital to make affiliated physicians accept assignment.

AMA's Todd maintained that the current assignment option is ''an important factor that has enabled physicians to treat Medicare patients in the same manner as other patients'' because there is no difference ''when it is time to submit bills for services.''

Todd argued that much of the out-of-pocket costs Medicare beneficiaries face today are program copayments and insurance costs. He added that the bills that represent the greatest hardship for patients are also the most likely to be assigned.

Observing that a study by the Health Care Financing Administration has indicated that two-thirds of physicians, if confronted with an ''all or nothing'' system, would take no assignments, Todd opposed any major changes in the assignment option on grounds that it could ''affect the access of Medicare patients to the physician of their choice.'' He called instead for ''administrative modifications to the physician billing and payment process that could eliminate some of the paperwork 'burden.' ''

Senate Unit Trims Medicare, Medicaid

A month of haggling and horsetrading in the Senate Finance Committee produced a deficit-trimming package that includes about $10 billion in Medicare and Medicaid cuts over the next 4 years.

Premium increases for Medicare beneficiaries and physician fee limits were scaled down somewhat from earlier versions of the proposal. The changes appeared to come at the expense of hospitals.

Finance's $74 billion deficit downpayment over 4 years would raise $48 billion in revenues largely through tax changes and reduce spending by $26 billion.

The physician fee proposal would produce an anticipated 4-year savings of $1.5 billion. It would freeze customary and prevailing fee limits for all physicians for 1 year beginning July 1, 1984. A freeze on prevailing fees only would continue for a second year for physicians who did not elect to become Medicare ''participating'' physicians agreeing to assign all claims.

Beneficiaries have been given some relief under the final proposal. A plan that would have gradually increased the Medicare Part B premium to 35% of Part B costs was replaced with a provision holding the Part B premium to 25% of costs.

The committee more than doubled its earlier cuts in Medicare payments to hospitals. In its final form, the Finance measure holds increases in the hospital specific portion of Medicare rates to the market basket increase minus ½%. The national and regional portion will be permitted to rise by the market basket plus ½%.

Other provisions would:

- Pay independent laboratories and physicians offices 60% and hospital labs 62% of prevailing charges for lab tests.
- Round payments for Part B claims down to the next lowest dollar.
- Require HHS to study the reasonableness of Part A payments for pacemaker implants and set up a pacemaker registry in the FDA.
- Require the establishment after July 1, 1984, of separate reimbursement limits for hospital-based and freestanding skilled nursing facilities. Limits would also vary according to whether the SNF was rural or urban.
- Disallow the re-evaluation of hospital assets acquired in fiscal 1985 and thereafter, thereby limiting the amount of capital related costs a new owner can claim for Medicare reimbursement purposes.
- Provide money from the Medicare trust funds to keep professional standards review organizations (PSROs) operating until they are replaced by peer review organizations (PROs).
- Delay the date by which all hospitals must contract with a PRO and after which intermediary PROs are permitted.

Organ Transplant Bills Move in Congress

Two organ transplant bills, both designed to ease organ procurement, worked their way through the House and Senate this March.

The more conservative bill, sponsored by Sen. Orrin Hatch (R-UT), would create a task force to review public and private efforts needed to set up an organ procurement system. The recommendations of the task force would not be mandated, but handed over to the President and two House and Senate committees for review.

It also permits the Department of Health and Human Services, if desired, to establish a national organ procurement and transplantation registry. Action is not required, explain supporters, because there is no consensus on the need for a federally-run procurement system.

The more radical bill, sponsored by Rep. Albert Gore (D-TN), would authorize grants to improve organ procurement, including participation in a new national transplantation network. It would also require HHS to set up a computerized national transplantation network to help match donors and recipients.

Most controversial, however, is a provision that gives HHS authority to ration the delivery of services to all Medicare recipients. Specifically, Title II of the House bill would allow the Secretary to determine for any ''health care technology or procedure'' paid for through the Medicare program, those Medicare beneficiaries who would be eligible for such services, those medical facilities in which the services can be provided, and the conditions under which the services would be provided.

While the Hatch bill has won the unanimous support of a Senate committee and seems headed for a warm reception on the Senate floor, the Gore bill faces a tougher fight in the House.

Specialists' Hospital Contract Legal, Court Says

An exclusive arrangement between a metropolitan hospital and a specialty group violates no anti-trust laws, the Supreme Court ruled in March in a case brought by a Louisiana anesthesiologist.

Although the arrangement may frustrate outside anesthesiologists and inconvenience surgeons, it does not restrain competition because other hospitals — without such an arrangement — are nearby, the justices agreed in a 9-0 decision.

East Jefferson General Hospital in Metairie, LA, has a contract with Roux and Associates to perform all anesthesiological services for its patients.

The arrangement was challenged by Edwin Hyde, MD, who was barred from admission to the hospital's staff. He charged the hospital with violation of the Sherman Anti-Trust Act.

In late 1982, an Appeals Court ruling found in Dr. Hyde's favor, saying that the arrangement was anti-competitive because patients in the hospital were ''compelled'' to use the hospital's anesthesiology services.

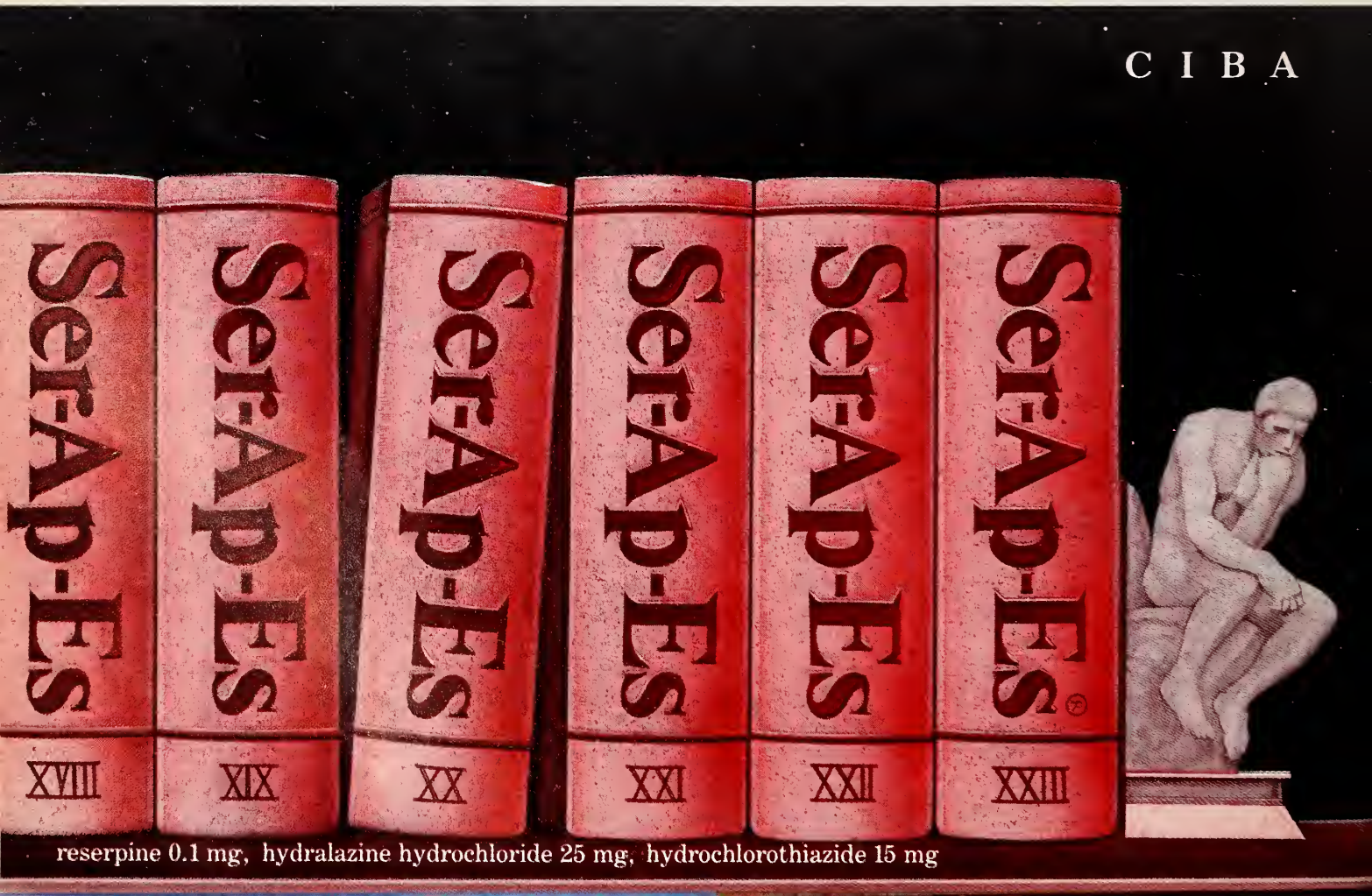
But the Supreme Court overturned the decision, finding that patients are not ''compelled'' to go to East Jefferson General Hospital; in fact, 70% of the patients residing in Jefferson Parish enter one of the 20 other hospitals in the area.

Even More Mandatory Assignment Proposed

The most far-reaching proposal yet for requiring physicians to accept Medicare assignment was introduced in March by House Aging Committee Chairman Edward R. Roybal (D-CA) with the backing of two major organizations representing the elderly.

Roybal's proposal would require physicians who accept payment from Medicare to take all claims on assignment, thus prohibiting the physician from charging patients in excess of Medicare's fee allowance. As enforcement, the bill would require hospitals participating in Medicare to deny staff privileges to any physician who refused to sign agreements to assign all Medicare claims.

The bill, which was touted at a press conference alleging that physicians ''overcharged'' Medicare patients by $2.5 billion or $107 per Medicare patient last year, is backed by 11 senior citizens groups, including the American Association of Retired Persons and the National Council of Senior Citizens.



Georgia Medical Student Section Delegation Participates in American Medical Association — Medical Student Section National Meetings

The Georgia medical student delegation and medical students from across the United States gathered at the Annual and Interim 1983 meetings in Chicago and Los Angeles to convene the American Medical Association Medical Student Assembly. The American Medical Association Medical Student Section, AMA-MSS, is composed of medical and osteopathic student members of the American Medical Association.

One resolution which was passed . . . asked that the AMA develop and distribute information stressing the importance of doing autopsies as a teaching and learning endeavor.

A membership category in the AMA was created for medical students in 1972 as an outgrowth of previous medical student organization input into AMA activities. At that time, the Student Business Section began to meet twice yearly at the Annual and Interim AMA meetings. In 1976, 1977, and 1978, medical student participation in the AMA increased to include the addition of student members to AMA councils. In 1979 the structure in the student section changed. A more representative body was developed which called for a voting member from each medical school at national meetings. This structure is now called the Medical Student Assembly. The Medical Student Assembly is governed by a council elected from each of four demographic regions of the United States. The MSS Assembly operates in a similar manner to state and national AMA House of Delegates meetings. Reference committees hold hearings on resolutions that have been submitted by medical student members and on reports that have been submitted by various committees or the Governing Council. These resolutions and reports are then submitted to the Medical Student Assembly for debate and acceptance or rejection. Accepted resolutions are then passed on by the MSS delegate to the AMA House of Delegates. The purpose of the Medical Student Section is to provide student participation in the decision and policy-making process of the AMA. By participating in this process medical students hope to make a positive contribution to medical education, health care, the medical profession and future medical leadership.

The Georgia Delegation consists of students from each of Georgia's four medical schools. Delegates are chosen by each school's medical student chapter and the dean of the medical school. These delegates are Karolyn Kramer, Medical College of Georgia; Leon Dent, Morehouse; Susan Middleton, Emory University; Brent Box, Mercer University. Also attending the 1983 Assembly meetings were alternate delegates and other medical student section members from Emory and Morehouse. Each delegate is sponsored jointly by the Medical Association of Georgia and the delegate's medical school. The Medical Association of Georgia provides strong support for student input with staff help, MAG leadership enthusiasm and financial sponsorship.

Many diverse topics were presented as resolutions to the 1983 Medical Student Assembly by MSS members. The Annual — 83 meeting in Chicago saw such issues as drug advertising, the AMA's role in technology assessment, ethical and economic implications of new medical technology, organ donor/procurement problems, and dietary guidelines for Americans, to list a few of the many subjects presented. One resolution which was passed by the MSS and forwarded to the AMA House of Delegates asked that the AMA develop and distribute information stressing the importance of doing autopsies as a teaching and learning endeavor. Medical students noted that autopsies were being performed less often in both teaching and private practice and felt that emphasis was needed in this area. The AMA House of Delegates passed this student initiated resolution and the AMA responded by preparing material and devoting an entire issue of JAMA, September 2, 1983, to the subject of autopsies. This issue was distributed to all medical students, regardless of AMA membership. At the Interim — 83 meeting in Los Angeles several resolutions were submitted which are being discussed widely in the medical profession. A resolution concerning treatment of handicapped infants arose out of the Baby Doe case. Other subjects discussed were elderly abuse, medical cost containment, public funding of abortion, the rising cost of medical education, and minority physician involvement in the AMA. Another important event in the history of the medical student section was the approval of a MSS student seat on the AMA Board of Trustees.

Members of the Georgia delegation worked in reference committees and on the assembly floor to represent views of Georgia medical students on these and many other topics. One benefit of Georgia delegation participation is the opportunity to meet and share ideas with other students. From this exchange our delegation has had a chance to hear how other medical school chapters of the MSS have input to and interact with their local and state societies. We are also able to learn how other MSS leaders involve students in MSS activities and teach them about the role the AMA serves in medicine. Many states, such as Texas, have formed MSS state assemblies which meet to increase student involvement at the state level and to foster a relationship with their state AMA organization. On another level of participation at the national level, a member of the Georgia delegation has been in a prominent leadership role. Karolyn Kramer has served as the MSS representative to the Liaison Committee on Medical Education, the national accreditation body for all American medical schools.

The members of the Georgia Medical Student Section delegation would like to thank the Medical Association of Georgia for its support in sending delegates to the MSS Assembly. We believe that we have had an effective input into the MSS and the AMA. But equally important, we are bringing back information and new ideas which, we hope, will increase medical student participation in Georgia's own AMA activities.

MEDICAL MEETING CALENDAR

MAY

16 — *Augusta:* **Reproductive Endocrinology.** Category 1 credit. Contact Div. of Cont. Edu., MCG, Augusta 30912. PH:404/828-3967.

18 — *Atlanta:* **Childhood Arthritis Update.** Category 1 credit. Contact Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., NE, Atlanta 30322. PH:404/329-5695.

18-20 — *Augusta:* **Allergy and Immunology — Recent Advances.** Category 1 credit. Contact Div. of Cont. Ed., MCG, Augusta 30912. PH:404/828-3967.

24 — *Columbus:* **Recent Developments in the Diagnosis and Therapy of Hypertension and Renal Disease.** Category 1 credit. Contact Judy Anderson, Int. Med. Found., P.O. Box 311, Columbus 31902-0311. PH:404/571-1454.

30-June 2 — *Hilton Head, SC:* **American Academy of Clinical Anesthesiologists Spring Seminar.** Category 1 credit. Contact Donald G. Catron, M.D., Program Director, AACA, P.O. Box 11691, Knoxville, TN 37939-1681. PH:615/588-6279.

31 — *Valdosta:* **Cardiovascular Risk Factors in Children.** Category 1 credit. Contact Sandra Owen, Ga. Affil., American Heart Assn., Box 13589, Atlanta 30324. PH:404/261-2260.

JUNE

6-9 — *Atlanta:* **Society of Vascular Surgery and International Society for Cardiovascular Surgery Joint Meeting.** Contact Univ. of Tex., Health Science Ctr., 5323 Harry Hines Blvd., Dallas, TX 75235.

7-9 — *Atlanta:* **Clinical Topics in GYN-OB.** Category 1 credit. Contact Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., NE, Atlanta 30322. PH:404/329-5695.

11-14 — *Kiawah Island, SC:* **Internal Medicine.** AMA Category 1 and AAFP prescribed credit. Contact Div. of Cont. Ed., MCG, Augusta 30912. PH:404/828-3967.

21-23 — *Hilton Head, SC:* **Neurology.** AMA Category 1 and AAFP prescribed credits. Contact Div. of Cont. Ed., MCG, Augusta 30912. PH:404/828-3967.

21-23 — *Sea Island:* **Georgia Chapter, American Academy of Pediatrics Spring Meeting.** Category 1 credit. Contact William C. Mankin, Exec. Secy., Ga. Chapter, Amer. Acad. of Ped., 4059 Land O'Lakes Dr., N.E., Atlanta 30342. PH:404/327-3922.

JULY

12-14 — *Kiawah Island, SC:* **Obstetrics.** AMA Category 1 and AAFP prescribed credit. Contact Div. of Cont. Ed., MCG, Augusta 30912. PH:404/828-3967.

13-15 — *Sea Island:* **Providing Quality Medical Care in Your Practice.** Contact Southern Med. Assn., 2601 N. Highland Ave., Box 2446, Birmingham, AL.

23-25 — *Kiawah Island, SC:* **Pediatric Update — 1984.** AMA Category 1 and AAFP prescribed credit. Contact Div. of Cont. Ed., MCG, Augusta 30912. PH:404/828-3967.

26-28 — *Kiawah Island, SC:* **Clinical Genetics.** AMA Category 1 and AAFP prescribed credit. Contact Div. of Cont. Ed., MCG, Augusta 30912. PH:404/828-3967.

AUGUST

2-5 — *Kiawah Island, SC:* **Critical Care Medicine.** AMA Category 1 and AAFP prescribed credit. Contact Div. of Cont. Ed., MCG, Augusta 30912. PH:404/828-3967.

6-10 — *Hilton Head, SC:* **Your Practice, Your Money, Your Family.** Category 1 credit. Contact Div. of Cont. Ed., MCG, Augusta 30912. PH:404/828-3967.

11 — *Atlanta:* **Experimental Hematology.** Category 1 credit. Contact Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., NE, Atlanta 30322. PH:404/329-5695.

12-16 — *Amelia Island, FL:* **Abdominal and Neuroimaging — Interventional Techniques.** Category 1 credit. Contact Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., NE, Atlanta 30322. PH:404/329-5695.

13 — *Atlanta:* **Comprehensive Board Review in Internal Medicine.** Category 1 credit. Contact Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., NE, Atlanta 30322. PH:404/329-5695.

14-16 — *Atlanta:* **Let's Talk Family Planning.** Category 1 credit. Contact Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., NE, Atlanta 30322. PH:404/329-5695.

SEPTEMBER

6-8 — *Atlanta:* **Southeastern Occupational Health Conference.** Contact T. R. Hatfield, M.D., P.O. Box 71, West Point 31833. PH:404/756-7111 ext. 2204.

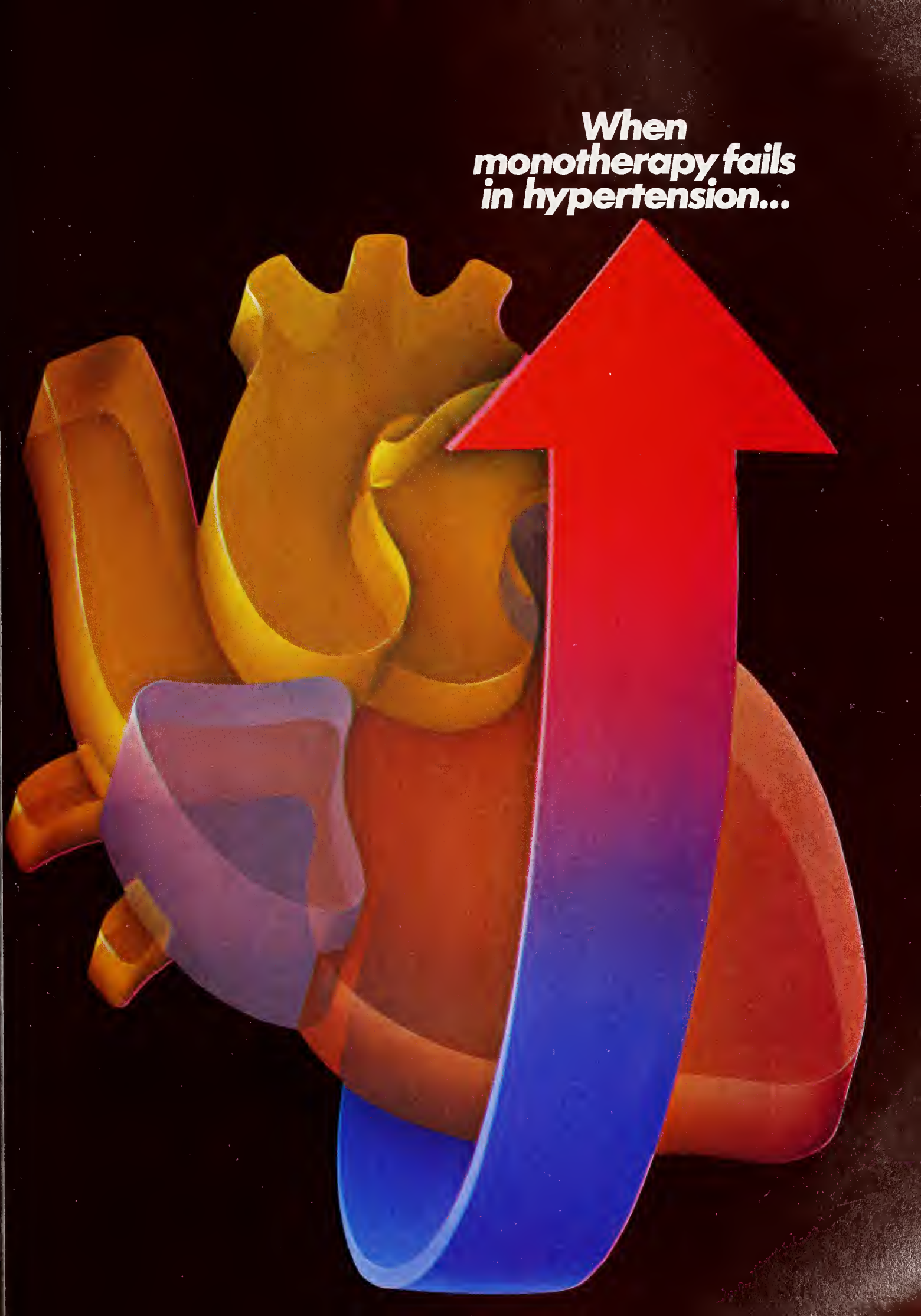
8-9 — *Hilton Head, SC:* **Fall Meeting of Georgia Society of Anesthesiologists.** Category 1 credit. Contact William Hammonds, M.D., Secy.-Treas., Dept. of Anesth., Emory Univ. Hosp., 1364 Clifton Rd., NE, Atlanta 30322. PH:404/321-0111.

12-14 — *Savannah:* **Neonatology — The Sick Newborn.** Category 1 credit. Contact Div. of Cont. Ed., MCG, Augusta 30912. PH:404/828-3967.

20-23 — *Sea Island:* **Georgia Surgical Society Annual Meeting.** Category 1 credit. Contact William McGarity, M.D., Emory Univ. Clinic, 1365 Clifton Rd., NE, Atlanta 30322. PH:404/321-0111, x 3322.

21-22 — *Atlanta:* **Office Urodynamics.** Contact Merrily Laube, Southern Found. for Edu. and Medical Research, Inc., 98 Currier St., Atlanta 30308. PH:404/688-3323.

28-30 — *St. Simons Island:* **Georgia Gastroenterologic Society Annual Scientific Sessions.** Category 1 credit. Contact Theodore Hersh, M.D., Emory Univ. Clinic, 1365 Clifton Rd., NE, Atlanta 30322. PH:404/321-0111.


When
monotherapy fails
in hypertension...


SQUIBB

The power to control hypertension... with greater convenience

A COMBINATION OF TIME-PROVEN AGENTS

for an additive effect in reducing hypertension*

- ☐ CORZIDE combines the advantages of CORGARD®(nadolol) — the highly effective once-a-day beta-blocker — and a classic once-a-day thiazide
- ☐ CORZIDE reduces blood pressure, as demonstrated in clinical trials

for a low incidence of side effects†

- ☐ CORZIDE was well tolerated in 102 patients evaluated for adverse reactions
- ☐ Hydrophilic (water-soluble) CORGARD does not readily cross the blood-brain barrier and is likely to cause fewer CNS side effects than lipophilic agents

for superior convenience

- ☐ Simple once-a-day dosage enhances patient compliance
- ☐ May be administered without regard to meals
- ☐ Available in two tablet strengths:
  CORZIDE® 40/5 (Nadolol 40 mg and Bendroflumethiazide 5 mg per tablet)
  CORZIDE® 80/5 (Nadolol 80 mg and Bendroflumethiazide 5 mg per tablet)

*This fixed combination drug is not indicated for initial therapy of hypertension. It may be appropriate if the fixed combination represents the dosage as titrated to the individual patient's needs.

†Please see brief summary of prescribing information on the last page of this advertisement for a discussion of CONTRAINDICATIONS, PRECAUTIONS, ADVERSE REACTIONS and WARNINGS, including avoidance of abrupt withdrawal.

ONCE-A-DAY CORZIDE®

Nadolol-Bendroflumethiazide Tablets

An important advance in Step-2 antihypertensive therapy

For brief summary please see next page.

ONCE-A-DAY CORZIDE®

Nadolol-Bendroflumethiazide Tablets

SQUIBB

An important advance in Step-2 antihypertensive therapy

CORZIDE® 40/5
CORZIDE® 80/5
Nadolol-Bendroflumethiazide Tablets

DESCRIPTION: CORZIDE (Nadolol-Bendroflumethiazide Tablets) for oral administration combines two antihypertensive agents: CORGARD® (nadolol), a nonselective beta-adrenergic blocking agent, and NATURETIN® (bendroflumethiazide), a thiazide diuretic-antihypertensive. Formulations: 40 mg and 80 mg nadolol per tablet combined with 5 mg bendroflumethiazide.

CONTRAINDICATIONS: Nadolol — Bronchial asthma, sinus bradycardia and greater than first degree conduction block, cardiogenic shock, and overt cardiac failure (see WARNINGS). **Bendroflumethiazide** — Anuria, and in those with previous hypersensitivity to bendroflumethiazide or other sulfonamide-derived drugs.

WARNINGS: Nadolol — **Cardiac Failure** — Sympathetic stimulation may be a vital component supporting circulatory function in patients with congestive heart failure, and its inhibition by beta-blockade may precipitate more severe failure. Although beta-blockers should be avoided in overt congestive heart failure, if necessary, they can be used with caution in patients with a history of failure who are well compensated, usually with digitalis and diuretics. Beta-adrenergic blocking agents do not abolish the inotropic action of digitalis on heart muscle. IN PATIENTS WITHOUT A HISTORY OF HEART FAILURE, continued use of beta-blockers can, in some cases, lead to cardiac failure. Therefore, at the first sign or symptom of heart failure, digitalize and/or give diuretics, and closely observe response, or discontinue nadolol (gradually, if possible).

Exacerbation of Ischemic Heart Disease Following Abrupt Withdrawal — Hypersensitivity to catecholamines has been observed in patients withdrawn from beta-blocker therapy; exacerbation of angina and, in some cases, myocardial infarction have occurred after *abrupt* discontinuation of such therapy. When discontinuing chronic use of nadolol, particularly in patients with ischemic heart disease, gradually reduce dosage over a 1- to 2-week period and carefully monitor the patient. Reinstitute nadolol promptly (at least temporarily) and take other measures appropriate for management of unstable angina if angina markedly worsens or acute coronary insufficiency develops. Warn patients not to interrupt or discontinue therapy without physician's advice. Because coronary artery disease is common and may be unrecognized, it may be prudent not to discontinue nadolol therapy abruptly even in patients treated only for hypertension.

Nonallergic Bronchospasm (e.g., chronic bronchitis, emphysema) — PATIENTS WITH BRONCHOSPASTIC DISEASES SHOULD IN GENERAL NOT RECEIVE BETA-BLOCKERS. Administer nadolol with caution since it may block bronchodilation produced by endogenous or exogenous catecholamine stimulation of $beta_2$ receptors. **Major Surgery** — Because beta blockade impairs the ability of the heart to respond to reflex stimuli and may increase the risks of general anesthesia and surgical procedures, resulting in protracted hypotension or low cardiac output, it has generally been suggested that such therapy should be withdrawn several days prior to surgery. Recognition of the increased sensitivity to catecholamines of patients recently withdrawn from beta-blocker therapy, however, has made this recommendation controversial. If possible, withdraw beta-blockers well before surgery takes place. In emergency surgery, inform the anesthesiologist that the patient is on beta-blocker therapy. Use of beta-receptor agonists such as isoproterenol, dopamine, dobutamine, or levarterenol can reverse the effects of nadolol. Difficulty in restarting and maintaining the heart beat has also been reported with beta-adrenergic receptor blocking agents. **Diabetes and Hypoglycemia** — Beta-adrenergic blockade may prevent the appearance of premonitory signs and symptoms (e.g., tachycardia and blood pressure changes) of acute hypoglycemia. This is especially important with labile diabetics. Beta-blockade also reduces release of insulin in response to hyperglycemia; therefore, it may be necessary to adjust dose of antidiabetic drugs. **Thyrotoxicosis** — Beta-adrenergic blockade may mask certain clinical signs (e.g., tachycardia) of hyperthyroidism. To avoid abrupt withdrawal of beta-adrenergic blockade which might precipitate a thyroid storm, carefully manage patients suspected of developing thyrotoxicosis.

Bendroflumethiazide — Use with caution in severe renal disease. In patients with renal disease, azotemia may be precipitated. With impaired renal function, effects of the drug may be cumulative. Use with caution in impaired hepatic function or progressive liver disease, since minor alterations of fluid and electrolyte balance may precipitate hepatic coma. Sensitivity reactions may occur in patients with a history of allergy or bronchial asthma. Possibility of exacerbation or activation of systemic lupus erythematosus has been reported.

PRECAUTIONS: General — **Nadolol** — Use with caution in patients with impaired hepatic or renal function (see DOSAGE AND ADMINISTRATION).

Bendroflumethiazide — At appropriate intervals, perform serum electrolytes determination to detect possible electrolyte imbalance warning signs of which are dryness of mouth, thirst, weakness, lethargy, drowsiness, restlessness, muscle pains or cramps, muscular fatigue, hypotension, oliguria, tachycardia, and G.I. disturbances such as nausea and vomiting. Observe patients for clinical signs of fluid or electrolyte imbalance; namely, hyponatremia, hypochloremic alkalosis, hypokalemia. Serum and urine electrolyte determinations are particularly important when the patient is vomiting excessively or receiving parenteral fluids. Drugs such as digitalis may influence serum electrolytes. Hypokalemia may develop, especially with brisk diuresis, in presence of severe cirrhosis. Interference with adequate oral electrolyte intake will also contribute to hypokalemia. Response of the heart to toxic effects of digitalis can be exaggerated with hypokalemia. Use potassium supplements such as high potassium foods to avoid or treat hypokalemia. Any chloride deficit is generally mild and usually does not require specific therapy except under extraordinary circumstances (as in liver or renal disease). Dilutional hyponatremia may occur in edematous patients in hot weather; appropriate therapy is water restriction rather than salt administration except in rare instances when the hyponatremia is life threatening. In actual salt depletion, appropriate replacement is the therapy of choice.

Hyperuricemia may occur or frank gout may be precipitated in certain thiazide-treated patients. Latent diabetes mellitus may become manifest during thiazide therapy. Antihypertensive effects of bendroflumethiazide may be enhanced in the postsympathectomy patient.

Careful reappraisal of therapy and consideration given to withholding or stopping diuretic therapy is necessary if rising nonprotein nitrogen or BUN (indicative of progressive renal impairment) occurs. Thiazides may decrease serum PBI levels without signs of thyroid disturbance. Thiazides decrease calcium excretion. Pathologic changes in parathyroid gland with hypercalcemia and hypophosphatemia have been occasionally observed with prolonged therapy. Common complications of hyperparathyroidism have not been seen.

Information for Patients — Warn patients, especially those with evidence of coronary artery insufficiency, against interruption or discontinuation of nadolol without physician's advice. Although cardiac failure rarely occurs in properly selected patients, advise patients being treated with beta-adrenergic blocking agents to consult physician at the first sign or symptom of impending failure. Advise patients of proper course if dose inadvertently missed.

Laboratory Tests — Regularly monitor serum and urine electrolyte levels (see WARNINGS, *Bendroflumethiazide,* and PRECAUTIONS, *General, Bendroflumethiazide).*

Drug Interactions — **Nadolol** — When administered concurrently the following drugs may interact with beta-adrenergic blocking agents: **Anesthetics, general** — exaggeration of anesthetic-induced hypotension (see WARNINGS, *Nadolol, Major Surgery).* **Antidiabetic drugs (oral agents and insulin)** — hypoglycemia or hyperglycemia; adjust antidiabetic drug dosage accordingly (see WARNINGS, *Nadolol, Diabetes and Hypoglycemia).* **Catecholamine-depleting drugs (e.g., reserpine)** — additive effect; monitor closely for evidence of hypotension and/or excessive bradycardia.

Bendroflumethiazide — When administered concurrently the following drugs may interact with thiazide diuretics: **Alcohol, barbiturates, or narcotics** — may potentiate orthostatic hypotension. **Antidiabetic drugs (oral agents and insulin)** — thiazide-induced hyperglycemia may require adjustment of antidiabetic drug dosage. **Other antihypertensive drugs** — additive or potentiated effect. **Corticosteroids, ACTH** — intensified electrolyte depletion, particularly hypokalemia. **Ganglionic or peripheral adrenergic blocking drugs** — potentiated effect: **Preanesthetic and anesthetic agents** — effects may be potentiated; adjust dosage accordingly. **Pressor amines (e.g., norepinephrine)** — possible decrease response but not sufficient to preclude their use. **Skeletal muscle relaxants, nondepolarizing (e.g., tubocurarine)** — possible increased response.

Drug/Laboratory Test Interactions — Discontinue thiazides before tests for parathyroid function (see PRECAUTIONS, *General, Bendroflumethiazide).*

Carcinogenesis, Mutagenesis, Impairment of Fertility — Nadolol — In 1 to 2 years oral toxicologic studies in mice, rats, and dogs, nadolol did not produce significant toxic effects. In 2-year oral carcinogenic studies in rats and mice, nadolol did not produce neoplastic, preneoplastic, or nonneoplastic pathologic lesions. **Bendroflumethiazide** — Long-term studies in animals have not been performed.

Pregnancy — **Teratogenic Effects** — **Nadolol** — Category C. In animal reproduction studies with nadolol, evidence of embryo- and fetotoxicity was found in rabbits, but not in rats or hamsters, at doses 5 to 10 times greater (on a mg/kg basis) than the maximum indicated human dose; no teratogenic potential was seen in any of these species. There are no well-controlled studies in pregnant women; therefore, use nadolol in pregnant women only if potential benefit justifies potential risk to the fetus. **Bendroflumethiazide** — Category C. Animal reproduction studies have not been conducted. This drug's effect on the fetus when administered to a pregnant woman or its effect on reproductive capacity is not known. Bendroflumethiazide should be given to a pregnant woman only if clearly needed. **Nonteratogenic Effects** — Since thiazides cross the placental barrier and appear in cord blood, weigh anticipated benefit of the drug in pregnant women against possible hazards to the fetus; these hazards include fetal or neonatal jaundice, thrombocytopenia, and possibly other reactions which have occurred in adults.

Nursing Mothers — Both nadolol and bendroflumethiazide are excreted in human milk. Because of the potential for serious adverse reactions in nursing infants either discontinue nursing or discontinue therapy, taking into account the importance of CORZIDE (Nadolol-Bendroflumethiazide Tablets) to the mother.

Pediatric Use — Safety and effectiveness in children have not been established.

ADVERSE REACTIONS: Nadolol — Most adverse effects have been mild and transient and have rarely required nadolol withdrawal. **Cardiovascular** — Bradycardia with heart rates of less than 60 beats per minute occurs commonly, and heart rates below 40 beats per minute and/or symptomatic bradycardia were seen in about 2 of 100 patients. Symptoms of peripheral vascular insufficiency, usually of the Raynaud type, have occurred in approximately 2 of 100 patients. Cardiac failure, hypotension, and rhythm/conduction disturbances have each occurred in about 1 of 100 patients. Single instances of first degree and third degree heart block have been reported; intensification of AV block is a known effect of beta-blockers (see also CONTRAINDICATIONS, WARNINGS, and PRECAUTIONS). **Central Nervous System** — Dizziness or fatigue reported in approximately 2 of 100 patients; paresthesias, sedation, and change in behavior reported in approximately 6 of 1000 patients. **Respiratory** — Bronchospasm reported in approximately 1 of 1000 patients (see CONTRAINDICATIONS and WARNINGS). **Gastrointestinal** — Nausea, diarrhea, abdominal discomfort, constipation, vomiting, indigestion, anorexia, bloating, and flatulence each reported in 1 to 5 of 1000 patients. **Miscellaneous** — Each of the following reported in 1 to 5 of 1000 patients: rash; pruritus; headache; dry mouth, eyes, or skin; impotence or decreased libido; facial swelling; weight gain; slurred speech; cough; nasal stuffiness; sweating; tinnitus; blurred vision. Although relationship to drug usage is not clear, sleep disturbances have been reported. The oculomucocutaneous syndrome associated with practolol has not been reported with nadolol. The following adverse reactions may also occur: **Central Nervous System** — reversible mental depression progressing to catatonia; visual disturbances; hallucinations; an acute reversible syndrome characterized by disorientation for time and place, short-term memory loss; emotional lability with slightly clouded sensorium, decreased performance on neuropsychometrics. **Gastrointestinal** — mesenteric arterial thrombosis; ischemic colitis. **Hematologic** — agranulocytosis; thrombocytopenic or nonthrombocytopenic purpura. **Allergic** — fever combined with aching and sore throat; laryngospasm; respiratory distress. **Miscellaneous** — reversible alopecia; Peyronie's disease; erythematous rash; arterial insufficiency.

Bendroflumethiazide — **Gastrointestinal System** — anorexia, gastric irritation, nausea, vomiting, cramping, diarrhea, constipation, jaundice (intrahepatic cholestatic jaundice), pancreatitis. **Central Nervous System** — dizziness, vertigo, paresthesia, headache, xanthopsia. **Hematologic** — leukopenia, agranulocytosis, thrombocytopenia, aplastic anemia. **Dermatologic-Hypersensitivity** — purpura, photosensitivity, rash, urticaria, necrotizing angiitis (vasculitis, cutaneous vasculitis). **Cardiovascular** — orthostatic hypotension may occur. **Other** — hyperglycemia, glycosuria, occasional metabolic acidosis in diabetics, hyperuricemia, allergic glomerulonephritis, muscle spasm, weakness, restlessness. Whenever adverse reactions are moderate or severe, thiazide dosage should be reduced or therapy withdrawn.

OVERDOSAGE: Nadolol may cause excessive bradycardia, cardiac failure, hypotension, or bronchospasm if overdosed. Overdosage of thiazides may cause lethargy, which may progress to coma within a few hours, with minimal depression of respiration and cardiovascular function and without evidence of serum electrolyte changes or dehydration. Gastrointestinal irritation and hypermotility may occur. Transitory increase in BUN and serum electrolyte changes may occur, especially in patients with renal impairment.

Treatment — Nadolol can be removed from the general circulation by hemodialysis. In determining duration of corrective therapy, take note of the long duration of the effect of nadolol. In addition to gastric lavage, employ the following measures, as appropriate. **Excessive Bradycardia** — Administer atropine (0.25 to 1.0 mg). If there is no response to vagal blockade, administer isoproterenol cautiously. **Cardiac Failure** — Administer a digitalis glycoside and diuretic. It has been reported that glucagon may also be useful in this situation. **Hypotension** — Administer vasopressors, e.g., epinephrine or levarterenol. (There is evidence that epinephrine may be the drug of choice.) **Bronchospasm** — Administer a $beta_2$-stimulating agent and/or a theophylline derivative. **Stupor or Coma** — Supportive therapy as warranted. **Gastrointestinal Effects** — Symptomatic treatment as needed. **BUN and/or Serum Electrolyte Abnormalities** — Institute supportive measures as required to maintain hydration, electrolyte balance, respiration, and cardiovascular and renal function.

DOSAGE AND ADMINISTRATION: DOSAGE MUST BE INDIVIDUALIZED. Patients with renal failure require adjustment in dosing interval; see package insert for dosage in these patients.

Consult package insert before prescribing CORZIDE (Nadolol-Bendroflumethiazide Tablets).

HOW SUPPLIED: Available as scored tablets containing 40 mg nadolol combined with 5 mg bendroflumethiazide and 80 mg nadolol combined with 5 mg bendroflumethiazide in bottles of 100

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JOURNAL
of the medical association of
georgia

The Community Care for the Elderly Act of 1982 — How Will It Affect the Private Practice of Medicine?

BENJAMIN B. OKEL, M.D., *Decatur**

WHAT GEORGIA INTERNIST or family practitioner hasn't felt frustrations similar to mine on seeing an elderly functionally impaired patient with no choice but to enter a nursing home when it was obvious that institutional care was neither necessary nor cost-effective? Georgia's older citizens currently comprise 91% of the state's nursing home population, and our state leads other southern states in number of nursing home beds per capita. In 1982, Georgia had 60.2 nursing home beds per 1000 persons 65 years or older, whereas Alabama had 47.6, Florida 20.8, North Carolina 31.6, South Carolina 35.1, and Tennessee 47.8. The resulting growth rate of Medicaid nursing homes expenditure has exceeded 12% per year, with nearly 40% of the current Medicaid budget allocated to the costs of institutional long-term care. National surveys show that approximately 25% of those elderly applying for nursing homes could be better served in community care.[1, 2]

In the 1982 session of the Georgia General Assembly, the Legislature addressed these problems and passed the Community Care for the Elderly Act. The intent of this legislation was "to assist functionally impaired elderly persons in living dignified and reasonably independent lives in their own homes or in the homes of relatives or caregivers through the development, expansion, reorganization and coordination of various community-based services."

* Dr. Okel practices cardiology and internal medicine. He is also Chairman, Board of Human Resources, DHR. Send reprint requests to him at 2195 N. Decatur Rd., Decatur, GA 30033.

Population forecasts indicate that our legislators acted none too soon. In 1980, a total of 516,731 persons, or 9.5% of the state population, were 65 years of age or older. It is predicted that by the end of this decade, 671,678 persons, or 10.4% of the state's population, will be in this age group. Patients over 75 now account for 65% of the nursing home admissions but will increase even more significantly in the near future. In 1980, there were 185,857 Georgians in this group. By 1985, there will be 228,375 and by the beginning of the next decade, 269,928 — a growth rate of 45%. Coping with the needs of the elderly will be a major social and health problem as we approach the end of this century.

The author describes how this Act offers opportunity for physicians in private practice to better serve their elderly patients through added community resources.

The Georgia Department of Human Resources (DHR) was mandated in the Act to plan and develop a system which will give older people a choice between institutional and community care. For more than a year, DHR and its Office of Aging have been working on such a plan. DHR Commissioner James Ledbetter appointed a citizen's task force which gathered research data, made on-site visits, and conducted public hearings throughout the state. The Office of Aging used the task force's final report and

recommendations to develop a 3-year plan and schedule for implementation. The agenda calls for the first services to begin in October of 1984, and community care is mandated to be statewide by July, 1985.

The Community Care program will be "community-based," i.e., each of the 18 state planning and service areas will develop and operate its own community care system. The program will be managed by a "lead agency" in each of these areas. Current plans call for the existing Area Agencies on Aging to receive first consideration for action as such lead agencies.

Each of these 18 community care systems must provide four specific services — assessment of functional impairment and needed community services, case management, homemaker services, and home health services — plus two others such as: in-home personal care, adult day care, alternative living services, respite care, and transportation.

Initially, the program will involve only Medicaid recipients certified for admission to nursing homes or elderly persons who would be eligible for Medicaid certification within 180 days of nursing home admission.

Each elderly person who applies for nursing home admission under Medicaid will be required to be evaluated by an assessment team consisting of a registered nurse, a social worker, and a physician. Current plans call for the assessment teams to be under the supervision and coordination of the District Health Officer.

In 1982, Georgia had 60.2 nursing home beds per 1000 persons 65 years or older, whereas Alabama had 47.6, Florida 20.8, North Carolina 31.6, South Carolina 35.1, and Tennessee 47.8.

The private physician will play a key role in that he will be referring patients into the community care system. The physician's evaluation of the patient and his advice will be crucial information for the assessment team's recommendation to the patient for either institutional or community care and for the team's development of a proposed plan of care.

A typical patient would come into the system by way of referral from the patient's physician to the District Health assessment team. This team will personally interview the patient and the patient's family, observe the patient's living conditions and family and social supports, and evaluate all other pertinent social and medical information related to the patient. The assessment team will then decide whether the patient is appropriate for nursing home care or community care and will develop a recommended plan of care for the patient and family to consider. The patient who chooses community care will be assigned a case manager who will keep track of the patient's condition and needs, and assure that regular re-evaluations are made so that the community services being provided continue to be appropriate and cost-effective.

It is essential that family physicians become aware of community care as an appropriate alternative (to nursing homes) for many patients and refer them . . . before that important, and often unchangeable, decision has been made.

A major problem which will be encountered in the system involves those elderly patients who would benefit from community care but who have already entered a nursing home. Therefore, it is essential that family physicians become aware of community care as an appropriate alternative for many patients and refer them to the assessment team before that important, and often unchangeable, decision has been made. In addition, many patients will be in need of acute care services. The physician must act quickly, not only in referring the patient to the assessment team but also in rapidly providing the team with all necessary information.

In summary, the Community Care Act of 1982 offers opportunity for physicians in private practice to better serve their elderly patients through added community resources. Soon Georgia's older citizens will have a choice between premature institutionalization and remaining in the community for as long as posssible.

Appreciation is expressed to Ms. Julie Cohn, Deputy Director, Office of Aging, Georgia Department of Human Resources, for her assistance in preparing this report.

References

1. Community Care Act Task Force Report, Georgia Department of Human Resources, 1983.
2. U.S. Accounting Office. Entering a nursing home — costly implications for Medicaid and the Elderly. 1979.

An updated look is taken at the mortality of rural/urban populations in the state, revealing some fascinating results.

Mortality in Rural Georgia

J. STEPHEN WRIGHT, Ph.D., *Statesboro,* and G. E. ALAN DEVER, Ph.D., M.T., *Macon**

Is COUNTRY LIVING really healthier than life in the big city? The typical Georgian will agree that living in a small town or the country is a positive health factor and adds years to one's life. However, previous research on the subject in Georgia shows mixed results. This question is probed in the research project presented here. An updated look is taken at the mortality of rural/urban populations in the state, revealing some fascinating results.

Background

The association between rural or urban residence and mortality is a subject of controversy. Until recently, urbanization was recognized as being associated with high mortality rates. Cities were characterized as notoriously unhealthy places,[1] probably as a result of the great epidemics of infectious diseases during the first days of modern public health practice. Higher death rates in urban areas have also been demonstrated for coronary heart disease,[2-4] deaths from all causes,[4, 5] and particularly for cancer.[6-12]

Recent studies, however, have reported higher infant and maternity mortality rates in rural areas,[13, 14] and some have reported higher crude (from all causes) death rates in rural areas.[15-17] Although these studies have indicated some disturbing trends associated with rural mortality, such factors as cause of death and age were not considered and little statistical testing was done.

In Georgia, much has been done to analyze health-related data and assess the health needs of state residents. For example, studies have been conducted by the state on the incidence of hypertension in metropolitan Atlanta[18] and disease patterns of black Georgians.[19] However, with the exception of a limited-scope study of rural health initiative in Georgia,[20] little information is available on the nature and magnitude of rural health problems. Two studies of mortality in Georgia in the 1950s and the 1960s reported a higher metropolitan death rate from cardiovascular disease for middle-aged white males[21] and the general population.[22]

Methods

Definitions and Data Source

Two indicators of rurality were used in this study. Counties of residence at the time of death were first defined as either metropolitan or non-metropolitan. Those counties designated as Standard Metropolitan Statistical Areas (SMSA) were considered metropolitan (or urban) and the remaining non-Standard Metropolitan Statistical Areas (non-SMSA) counties were considered non-metropolitan (or rural) areas.

The population density of each county, expressed as number of individuals per square mile, was used as a second indicator of rurality. Population per square mile seems to be a reasonably sound indicator of population density except that an underlying assumption is made that the population is dispersed over all of the area of the county.[11] This can be misleading when dealing with very large counties with nearly all the population concentrated in one area. This, however, is not the case in Georgia.

Mortality data were obtained from the Georgia Department of Human Resources for the calendar year 1979. The Georgia Office of Planning and Budget provided the estimates for the 1979 civilian, non-institutional population. The classification of counties as SMSA or non-SMSA was obtained from the U.S. Bureau of the Census.[23]

* Dr. Wright is Director, Office of Rural Health, Georgia Southern College; Dr. Dever is Director of Clinical Epidemiology and Biostatistics, Mercer University School of Medicine. Send reprint requests to Dr. Wright, Box 8148, Georgia Southern College, Statesboro, GA 30460.

Statistical Methods

Mortality rates were analyzed to determine the relative differences between rural and urban rates and the magnitude of those differences. The crude death rates as well as the 13 leading causes of death in Georgia were studied. Race and age sub-groups were established: white and black; 0-14 years, 15-44 years, 45-64 years, and 65-up years. All non-white residents were classified as black, since non-black minorities composed only a small part of the total population (less than 1%). For statistical purposes, any age-race-cause group with less than 30 deaths was eliminated.

Rural and urban age-specific, race-specific, and age-race-specific death rates from all causes were compared, and the significance of differences was tested using the ratio (R) for two independent rates.[24, 25] Age-race adjusted death rates from all causes were calculated using the direct method of adjustment and the pooled population (i.e., the state of Georgia population) as the standard population.

Standardized mortality ratios (SMRs), again with the state of Georgia as the standard, were also used for statistical comparisons of deaths from all causes as well as the 13 leading causes of death in Georgia. The SMR[25] was computed as follows:

$$\text{SMR} = \frac{\text{Observed Number of Deaths}}{\text{Expected Number of Deaths}} \times 100$$

An SMR value of 100 signifies that there is no difference between the observed and expected number of deaths. An SMR value of 125 indicates that the observed deaths are 25% above the expected. On the other hand, a value of 75 indicates that the observed deaths are 25% below the expected number. The significance of the SMRs was computed using an approximation of the standard error.[25]

A correlation analysis of the county density versus total mortality rate was conducted to determine the strength of association between rurality and mortality.

Results

In 1979, there were a total of 42,758 resident deaths from all causes reported in Georgia. The distribution of deaths and population by rural (non-SMSA) and urban (SMSA) area, age, and race, as well as the rural and urban rates and the significant differences between rates are presented in Table 1.

Total Mortality From All Causes

The crude death rate for the state of Georgia was 830.1/100,000 population. The rate for urban counties was 740.0/100,000 population and for rural counties, 952.3/100,000 population, or 28.7% greater than the urban rate. This difference in rates is statistically significant as are the differences for both whites and blacks ($p < 0.01$). When the death rate from all causes is adjusted for race and age, the difference decreases to a very large extent, but the rate is still significantly higher ($p < 0.01$) in rural counties than in urban counties (846.1 versus 821.6 per 100,000).

TABLE 1 — Rural and Urban Mortality, by Age and Race, Georgia, 1979

Age Group	Race	Rural (non-SMSA) Death rate per 100,000 (r_1)	Urban (SMSA) Death rate per 100,000 (r_2)	$R = \frac{r_1}{r_2}$
0-14	White	125.3	88.5	1.42†
	Black	211.4	203.4	1.04
	All	155.1	123.3	1.26†
15-44	White	187.1	146.5	1.28†
	Black	271.6	282.5	0.96
	All	211.4	182.5	1.16†
45-64	White	1124.9	947.3	1.19†
	Black	1694.6	1808.9	0.94
	All	1251.1	1126.0	1.11†
65 and up	White	5151.0	5225.9	0.98
	Black	4559.5	4978.2	0.92†
	All	5001.4	5160.3	0.97†
All ages	White	972.9	697.5	1.39†
	Black	900.8	859.3	1.05†
	All	952.3	740.0	1.29†

* $p < 0.05$
† $p < 0.01$

The unadjusted difference is much greater for whites than blacks (39% versus 5% higher than the urban). Mortality rates are significantly higher in rural areas for all age groups, except the 65-up year group which has a significantly higher urban rate ($p < 0.01$).

An interesting pattern was observed in the magnitude of the differences between urban and rural areas among the different age groups. The largest rate difference was 26% higher in rural, found in the 0-14 year group. This difference diminished with age — 16% (15-44 years) and 11% (45-64 years) higher in rural, and 3% lower in rural areas than urban areas (65-up years). When specific age-race groups are considered, all rural white groups with the exception of 65-up years had significantly higher rates than urban groups. The rate for this 65-up year group is 2% lower in rural areas, but the difference is not significant. In the black groups, the only significant difference was found in the older group where the urban rate is significantly higher than the rural rate.

With SMRs, the rural mortality was found to be significantly above what could be expected, and the urban mortality significantly below (both $p < 0.01$). As seen in Table 2, when the population is broken down into age groups, the rural groups, 0-14 years, 15-44 years, and 45-64 years, had mortality significantly ($p < 0.01$) above the expected, while the converse was found in the urban counties. In the

TABLE 2 — Summary of Findings for Mortality from All Causes

Age Group	*Race*	*Significantly higher rate*	*Significance of SMR**	
			Rural	*Urban*
0-14	White	Rural	Above	Below
	Black	NSD†	NSD	NSD
	All	Rural	Above	Below
15-44	White	Rural	Above	Below
	Black	NSD	NSD	NSD
	All	Rural	Above	Below
45-64	White	Rural	Above	Below
	Black	NSD	NSD	NSD
	All	Rural	Above	Below
65 and up	White	NSD	NSD	NSD
	Black	Urban	Below	Above
	All	Urban	NSD	NSD
All	White	Rural	Above	Below
	Black	Rural	NSD	NSD
	All	Rural	Above	Below

* SMR — Standardized Mortality Ratio
† NSD — No Significant Difference

65-up year group, no significant differences were detected for either rural or urban.

When race is considered, all white age groups conform to the same pattern. However, in the black group, only the 65-up year group exhibited significant differences, with the urban SMR significantly above the expected and the rural SMR below ($p < 0.01$).

Death From Specific Causes

In order to better understand these results and to reveal more about rural/urban differences, evaluations were made of mortality by the specific causes of death. Thirteen of the leading killers were studied in greater detail, accounting for 39,996 deaths or 94% of the 42,758 deaths in the state. Rural and urban SMRs are presented in Table 3.

Rural areas made a very poor showing as 9 of the top 13 classes of diseases showed significantly more deaths in rural counties than expected. Nine diseases also showed significantly fewer deaths in urban counties. Homicide was the only cause of death listed in which the SMR was significantly higher in urban counties and lower in rural counties than expected. The greatest differences between rural and urban mortality were motor vehicles (83%), cerebrovascular disease (56%), and urinary-related (53%). No significant differences were found between observed and expected SMRs for three causes (digestive-related, congenital anomalies, and suicide).

The 13 top causes of death were also studied in relation to age and race. SMRs were calculated for rural and urban Georgia by cause, race, and age group. Fifteen age-race-cause specific groups were found to have significant differences as shown in Table 4. High mortality predominated in rural coun-

TABLE 3 — Standardized Mortality Ratios for the Thirteen Leading Causes of Death, Georgia, 1979

Cause of Death (International Code)	*Number of Deaths*	*SMR*		*Ratio of SMRs*	*Difference*
		Rural	*Metropolitan*		
Heart Disease (390-398; 401-405; 410-429)	15,676	119.39†	85.70†	1.39	39%
Cancer (140-165; 170-175; 179-208)	7,868	108.50†	93.68†	1.16	16%
Cerebrovascular Disease (430-438)	4,600	126.06†	80.78†	1.56	56%
Respiratory-related (460-519)	2,610	113.56†	89.98†	1.26	26%
Motor Vehicles (810-825)	1,830	135.18†	74.05†	1.83	83%
Digestive-related (530-579)	1,638	103.56	97.35	1.06	NSD‡
Other Accidents (800-807; 826-949)	1,246	110.87†	92.44*	1.20	20%
Other Circulatory (440-459)	990	113.04†	90.36†	1.25	25%
Endocrine-related (240-259; 270-279)	977	113.57†	89.97†	1.26	26%
Homicide (960-969)	844	80.93†	113.99†	0.71	−29%
Urinary-related (580-599)	671	125.00†	81.54†	1.53	53%
Suicide (950-959)	659	100.85	99.41	1.01	NSD
Congenital Anomalies (740-759)	387	109.03	93.40	1.17	NSD
Total for Above Causes	39,996				
All Causes	42,758	114.72†	89.14†	1.29	28.7%

* $p < 0.05$
† $p < 0.01$
‡ NSD — No Significant Difference

TABLE 4 — Age-race-cause Specific Groups with Standardized Mortality Ratios Significantly Different than Expected, Georgia, 1979

Cause of Death	*Race*	*Age Group*	*Significant Differences* *Rural*	*Metropolitan*
Heart Disease	White	45-64	Higher†	Lower†
	White	65-up	NSD	Lower*
Cerebrovascular	White	45-64	Higher†	Lower†
Disease	Black	65-up	Higher†	Lower†
Motor Vehicle	White	0-14	Higher*	Lower†
		15-44	Higher†	Lower†
		45-64	Higher†	Lower†
		65-up	Higher†	Lower†
	Black	15-44	Higher†	Lower†
Other Accidents	White	15-44	Higher†	Lower*
Congenital Anomalies	White	15-44	Higher*	(a)
Digestive-related	Black	15-44	Lower†	NSD
Cancer	White	65-up	Lower†	Higher†
	Black	65-up	Lower†	Higher†
Homicide	Black	15-44	Lower†	Higher†

(a) SMR not calculated because there were only 21 deaths in this group.
* $p < 0.05$
† $p < 0.01$
NSD — No Significant Difference
NOTE: Groups not presented above were not significantly different.

ties from heart disease, cerebrovascular disease, motor vehicle accidents, other accidents, and congenital anomalies. Significantly higher urban mortality (SMRs) was found only with three age-race-cause specific groups, two caused by cancer and one by homicide. These findings are summarized in Table 5 in the form of age-race specific significant problems.

Population Density

There was a significant negative correlation between the rate of death from all causes in counties and density of counties ($p < 0.01$). The correlation coefficient of $-.334$ indicates that there is a significant inverse relationship between the county crude death rate and population density. As the population per square mile decreased (i.e., an increase in ruralness), mortality increased significantly and vice versa.

Discussion

The higher rural crude death rate (28.7% higher than the urban rate) is influenced strongly by the older rural population. The 65-up year component of the rural population is 11.7% of the total population as compared to 8.11% of the urban population. In actual numbers, this represents a difference of 16,639 more citizens of 65-up years in the rural population. The distribution of race is more equal: 26.3% of blacks in the urban counties versus 28.6% in the rural counties. However, the rural death rate is still significantly higher than the urban rate even after age-race adjustment. Moreover, as already seen, there are many differences between rural and urban areas within specific age-race groups.

A reversal in the previously reported pattern of higher metropolitan/lower rural mortality is a significant finding of this study.

An almost linear relationship was found between age and the extent of the difference between urban and rural mortality. Rural mortality is much higher than urban mortality in the younger age group, but the difference decreases with age. For whites 0-14 years, the overall mortality rate is higher in rural areas. These excess deaths were found to be due

TABLE 5 — Significant Problems (Higher Than Expected Mortality Rate), By Age-race Specific Groups, Georgia, 1979

Group	*Rural (Non-SMSA)*	*Urban (SMSA)*
0-14 years White	Motor vehicle accidents	
0-14 years Black		
15-44 years White	Motor vehicle accidents, other accidents, congenital anomalies	
15-44 years Black	Motor vehicle accidents	Homicide
45-64 years White	Heart disease, cerebrovascular disease, motor vehicle accidents	
45-64 years Black		
65-up years White	Motor vehicle accidents	Cancer
65-up years Black	Cerebrovascular disease	Cancer
ALL	Heart disease, cancer, cerebrovascular disease, respiratory-related, motor vehicle accidents, other accidents, other circulatory, endocrine-related, urinary-related.	Homicide

primarily to motor vehicle accidents. Other causes of death are suspected of contributing to the high rural mortality in the 0-14 year group. However, many of these age-race-cause specific groups, especially the younger group, were eliminated from analysis because the actual number of deaths was too few to be statistically tested. Differences might be detected for additional specific causes of death in a multi-year analysis with a larger number of observations. The authors are currently working on a multi-year study.

The strong influence of an older population in rural counties has been noted as a contributing factor to the high mortality.

Motor vehicle accidents also contribute to the higher mortality rate in rural areas for whites over 14 years and blacks 15-44. The rural mortality rate for this cause of death in all groups is 83% more than the urban rate, making it the largest difference of the 13 causes of death. Poor roads and more roadside obstacles in rural Georgia and faster EMS response and transport times in urban areas likely play a role in the large rate difference.

Cardiovascular disease contributes substantially to the excess deaths occurring in rural counties. Heart disease in whites 45-64 and cerebrovascular disease in whites of the same age and in blacks 65-up account for this difference. These results contrast with the findings in several studies[2-4, 21] but are consistent with a report[11] which showed high non-metropolitan death rates from cardiovascular diseases in the Southeast.

Whites 15-44 years living in rural areas also have a higher overall death rate than their counterparts from the city. Congenital anomalies account for some of these additional deaths as do non-vehicular accidents.

While the findings of this investigation have shown the severity of rural mortality, not all of the age-race-cause specific groups followed this pattern. In the 65-up year group, the urban death rate is actually higher than the rural rate, the excess deaths resulting from cancer. The higher rate of cancer deaths in both whites and blacks over 64 in urban areas has been reported in several studies.[6-12] One possible explanation may be that cancer-causing chemicals which generally are concentrated in metropolitan areas may have a latent cumulative effect on the residents.

Death by homicide was also found to be higher in metropolitan areas than in rural for blacks 15-44. Public crime reports have indicated that more murders per capita occur in larger cities. These findings confirm that more victims are from urban areas than statistically expected.

The correlation analysis between crude death rate and density of counties provides another way to assess the relationship between rurality and death rate. The inverse correlation supports the findings that rural Georgia tends to have a higher mortality rate than urban Georgia.

Summary

Rural Georgia has a significantly higher crude death rate than urban Georgia (28.7% higher). The strong influence of an older population in rural counties has been noted as a contributing factor to the high mortality. However, when age and race adjustments were made and analyses done by age, race, and cause, in general the differences persisted.

Significant problems in rural areas for whites are motor vehicle accidents, heart disease, cerebrovascular disease, other accidents, and congenital anomalies, and for blacks, motor vehicle accidents and cerebrovascular disease. In metropolitan counties, cancer is a significant problem for the elderly of both races, while homicide is a significant problem for blacks.

A reversal in the previously reported pattern of higher metropolitan/lower rural mortality is a significant finding of this study. The wide gap between rural and urban mortality which has been revealed in this paper adds to the mounting body of evidence of a "health-disadvantaged" rural population in Georgia. High mortality coupled with physician and other health manpower shortages all contribute to a bleak health outlook for rural Georgia.

Acknowledgements

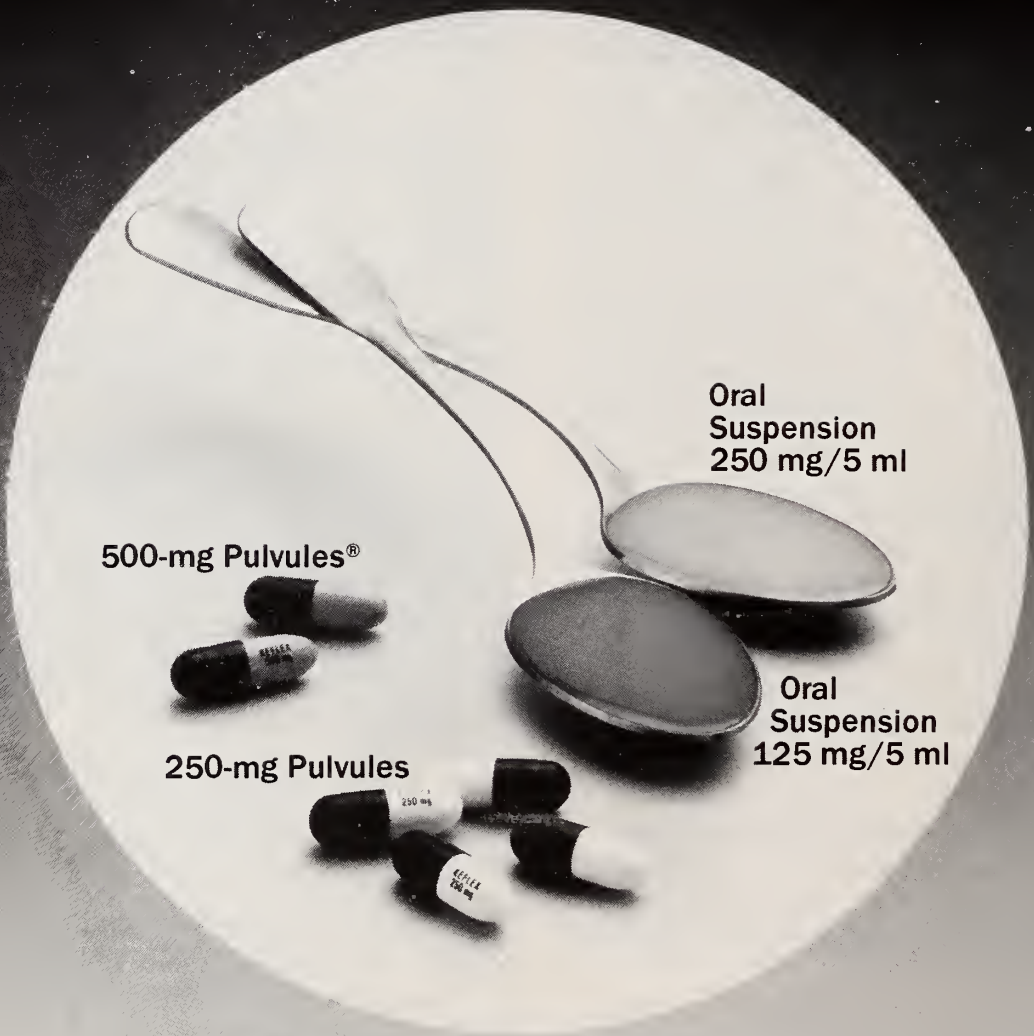
Special thanks are given to Dr. Frank Clark and Mr. Steven Sims who prepared the program and conducted the electronic analysis of data and to Dr. Francois Champagne for his assistance and valuable suggestions. Partial assistance for this research project was provided by a Georgia Southern College Faculty Research Grant.

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This case is unusual not only because it was community acquired and nonfatal but also because it did not manifest in the classic way.

Successful Treatment of *Pseudomonas* Pneumonia Complicated by Bacteremia and Empyema

DONALD R. ROBINSON, M.D., BASHIR A. CHAUDHARY, M.D., and WILLIAM A. SPEIR, M.D., *Augusta**

Introduction

Pseudomonas pneumonia with bacteremia usually occurs as a nosocomial infection among immune compromised patients and is associated with a mortality approaching 100%. We report a patient, without an underlying immune deficiency state, who developed *Pseudomonas* pneumonia outside the hospital environment. Even though he had associated *Pseudomonas* bacteremia and empyema, he was treated successfully with antibiotics and chest tube thoracostomy.

Case Report

A 78-year-old man was admitted to the Medical College of Georgia-Talmadge Memorial Hospital (MCG-TMH) in August, 1982, because of malaise, anorexia, cough, right sided chest pain, and fever of several days duration. He had a long history of smoking cigarettes and had been previously diagnosed as having chronic obstructive lung disease. He had been admitted to MCG-TMH in April, 1982, for evaluation of iron deficiency anemia and upper esophageal web.

At the time of admission, the patient had a temperature of 37.4°C, blood pressure 105/70 mmHg, respiration 20/min, and pulse 100/min. Examination of the chest revealed dullness to percussion and loud inspiratory and expiratory crackles at the right lung base. The remainder of the physical examination was unremarkable. The chest roentgenogram revealed an extensive right lower lobe infiltrate (Figure 1). Other laboratory data included: hemoglobin 12.5g%, white blood count 24,000/mm^3 with 85%



Figure 1 — Chest roentgenogram at admission, showing a right lower lobe infiltrate.

* From the Section of Pulmonary Diseases, Department of Medicine, Medical College of Georgia, Augusta, GA. Send reprint requests to Dr. Chaudhary, Associate Professor of Medicine, Section of Pulmonary Diseases, Department of Medicine, MCG, Augusta, GA 30912.

This paper was prepared at the request of the Georgia Thoracic Society.

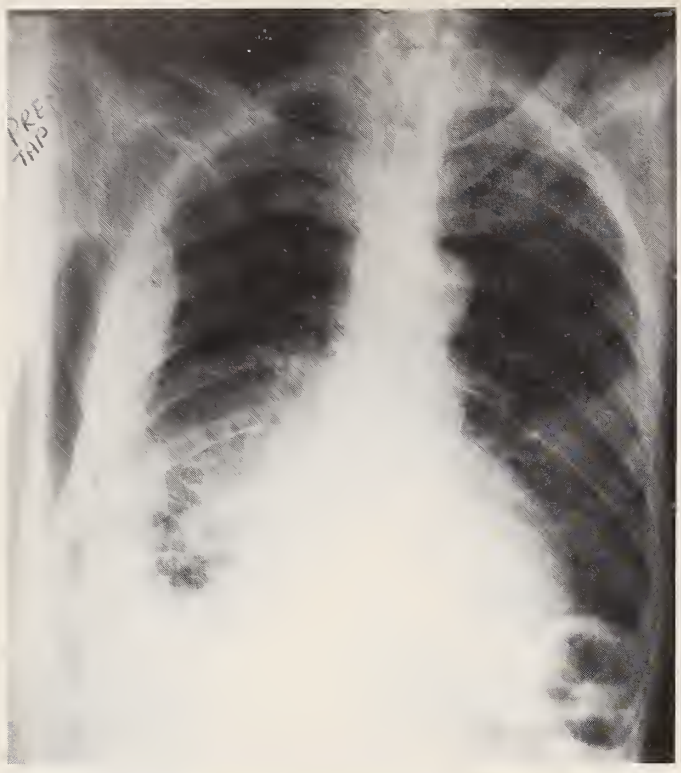


Figure 2 — Chest roentgenogram 1 week after admission, showing an extensive pleural effusion.



Figure 3 — Follow-up chest roentgenogram, showing resolution of pneumonia and empyema.

polymorphonuclear leukocytes and 22% bands. Sputum examination showed numerous gram-negative bacilli and polymorphonuclear leukocytes. Sputum cultures grew mixed organisms including *Pseudomonas aeruginosa*. Blood cultures grew gram-negative bacilli, later identified as *Pseudomonas aeruginosa*. The patient was begun on cefamandole intravenously.

Twenty-four hours after admission cefamandole was discontinued, and he was started on tobramycin and ticarcillin intravenously. One week following admission, the patient began having increased dyspnea and pain in the right upper quadrant of the abdomen and the right lower chest. A chest roentgenogram showed a loculated pleural effusion on the right (Figure 2). Thoracentesis was performed, and 50 ml. of cloudy, straw-colored fluid was aspirated. Analysis of the fluid revealed a white blood cell count of 14,000/mm^3 with 95% polymorphonuclear leukocytes, LDH 752 mu/ml, and pH of 7.16. A chest tube was inserted with drainage of 1000 ml. of purulent, hemorrhagic fluid over several days. Cultures of the pleural fluid grew *Pseudomonas aeruginosa*. Antibiotic therapy was continued, and the patient gradually improved. He was discharged 1 month after admission. No evidence of immune deficiency was found during the hospitalization. He has been followed as an outpatient, and a subsequent chest roentgenogram showed clearing of the infiltrate (Figure 3).

Discussion

Bacteremic *Pseudomonas aeruginosa* pneumonia occurs, as a rule, in hospitalized patients with depressed immune systems and may result in vasculitis and infarction of the lung.[1] Community-acquired bacteremic *Pseudomonas* pneumonia is distinctly unusual, although it has been reported even among previously healthy adults.[2, 3] Other than advanced age, the only significant risk factor in our patient was chronic obstructive lung disease, which Tillotson[4] noted frequently among patients with nonbacteremic *Pseudomonas* pneumonia.

Pseudomonas pneumonia classically begins abruptly with apprehension, confusion, chills, high fever, severe dyspnea, and systemic toxicity.[4] In contrast, our patient was alert, did not seem apprehensive, manifested only a low grade fever throughout his hospital course, and did not appear particularly toxic until an empyema developed.

Review of the literature on bacteremic *Pseudomonas* pneumonia is remarkable for the finding of a nearly universally fatal outcome. In a review of 49 cases, Iannini[5] noted only one survivor, while Pennington,[1] reporting on 36 cases of *Pseudomonas* pneumonia over a 15-year period at the National Institutes of Health, found a fatal outcome in all nine patients with bacteremia. Likewise, Baltch and Griffin[6] and Fishman and Armstrong[7] reported mortality rates of 88% and 91%. These results do not necessarily reflect optimal, current therapy since most patients were treated with a single drug and

only a small minority were treated with an effective, synergistic combination of aminoglycoside and semisynthetic penicillin. Yet, among a total of seven patients from Pennington's and Iannini's series treated with gentamicin and carbenicillin, mortality was 100%. Certainly, the presence of such significant host factors as leukopenia and hematologic malignancy, frequent in these studies, would severely limit the effectiveness of any therapeutic regimen.

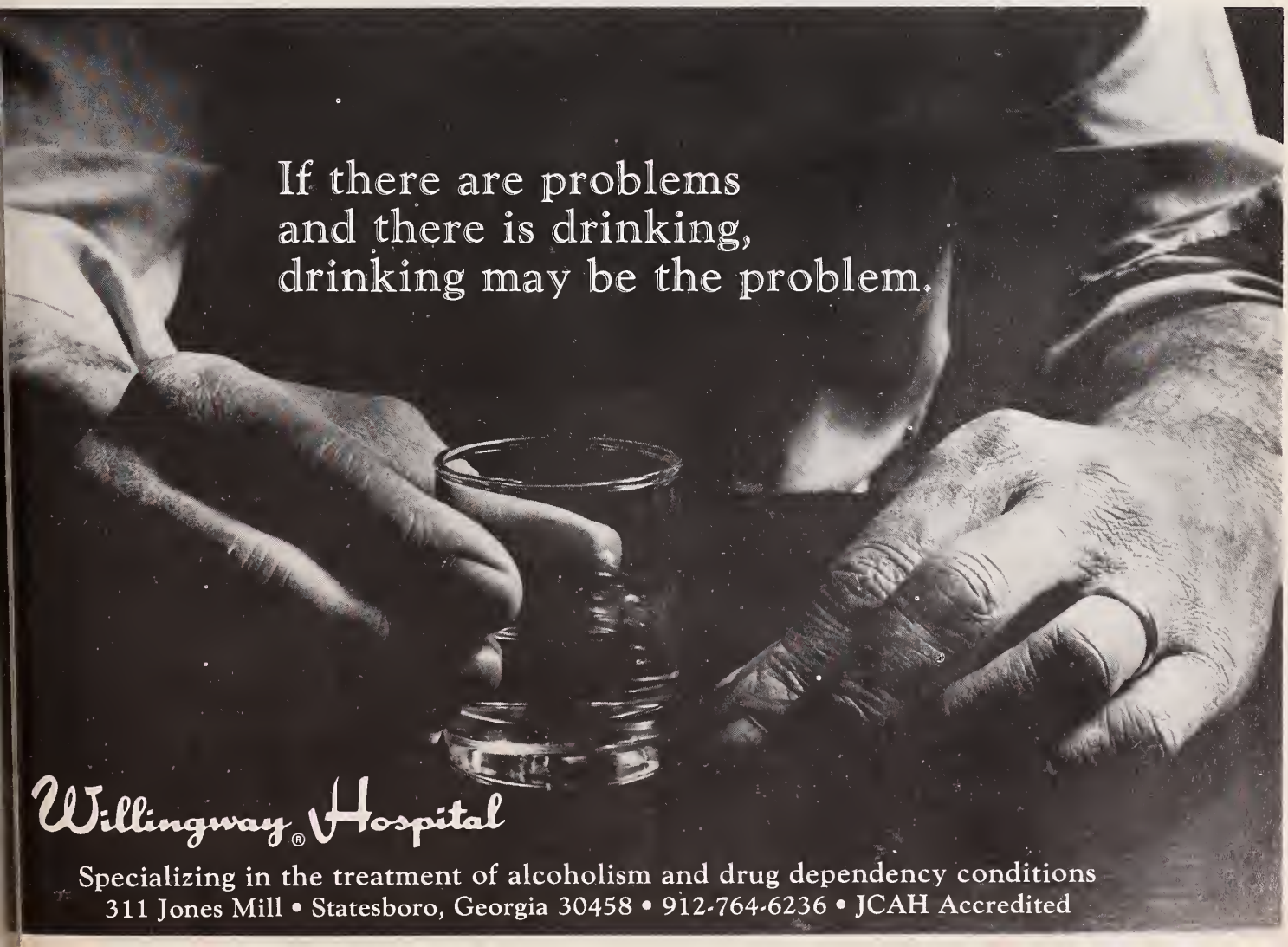
Our patient should be added to two recent case reports of successful treatment of bacteremic *Pseudomonas* pneumonia.[2, 3] While all three patients received effective two drug therapy, host factors may have played an even more significant role; our patient had only mild underlying disease, and the other two patients were reported to be in good health.

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The story of a remarkable man who has contributed much to the country he adopted.

Greek Physician Finds America "A Promised Land"

EVELYN WARD GAY, *Decatur**

DR. JOHN ELIAS SKANDALAKIS is openly proud to be a citizen of the United States.

"The best people on earth live here," he says with contagious enthusiasm. "It is a promised land. Everyone wants to come here, to stay here and die here."

Many good things have happened to the Atlanta surgeon since he arrived in this country from his native Greece 33 years ago, but what he calls "the greatest honor of my life" came in 1981 when he was named by Governor George Busbee as a regent-at-large with the University System of Georgia. On July 1, 1983, he was chosen chairman of the Board of Regents.

Asked why he thinks he is the only person not born in this country to ever hold a position on the Board, he states simply, "I don't know, but I have always considered myself an educator."

The word "education" pops up often in his conversation, and it is obvious that it always has been one of his major interests. Although he is an active practitioner in his profession, he gives a great deal of time to teaching and to all activities involved in the educational process.

The University System of Georgia is made up of 33 institutions of higher learning, he explains, and the Board of Regents meets for a 2-hour session each month. There are 15 members of the Board, one from each congressional district and five members-at-large.



John E. Skandalakis, M.D.

An Historic Perspective of the University System

At the time Dr. Skandalakis was named to the post, the Board was celebrating its Golden Jubilee. The University System of Georgia was begun in 1784, little more than 50 years after the first settlement was started at Savannah, when 40,000 acres of land were set aside in trust by the General Assembly for the endowment of "a college or seminary of learning." The next year, a charter was granted for the establishment of Franklin College, later to become the University of Georgia.

Land grant colleges were begun in the state following the Civil War, but most of the operating costs

* Mrs. Gay is Chairman of the Research and Romance of Medicine Committee of the Auxiliary of the MAG. Her address is 911 Vistavia Circle, Decatur, GA 30033.



The Board of Regents of the University System of Georgia (minus 3 members) met recently with Governor Joe Frank Harris at the State Capitol. Dr. Skandalakis is standing third from the governor's left.

came from the federal government. It was not until 1877 that the Constitution of Georgia provided appropriations for education, and branches of the university were begun in Atlanta, Milledgeville, Savannah, and Valdosta. Several others followed in the next few years. These were loosely run schools, however, with no control organization for administering funds or overseeing facilities.

It was another physician, Dr. Lamartine G. Hardman, then serving a second term as Governor of Georgia, who in 1929 named a committee of prominent Georgians to make a survey of higher educational institutions in the state. Out of this study came a proposal suggesting a centralized control over the various schools and coordination of all degree programs. The establishment of the Board of Regents of the University System of Georgia was the result. Under the Reorganization Act of 1931, the Board became responsible for 26 institutions in the state, including the Medical College of Georgia in Augusta.

Dr. Skandalakis says that he has enjoyed his association with the Board over the past 3 years and looks forward to the remainder of his term which ends in 1988. In the meantime, he maintains an ever-increasing role in medicine and medical education in his adopted state and nation.

Personal Background

Born in Molai, Sparta, Greece, shortly after World War I, he describes the village where he grew up as "a nice little town of about 3000 population in the mountains, a typical Greek town with a church in the square and many small churches in the surrounding hills." He attended 6 years of elementary school, 6 of high school, and 6 of medical school, graduating with an M.D. degree in 1946 from the University of Athens, Greece. In 1950, he received an M.S. degree in surgery from the same university after spending 4 years as an intern and extern in the First Surgical Clinic of Athens University and as a First Lieutenant in the Royal Greek Navy's Medical Corps. That same year he was certified by the Greek Board of Surgery. For 1 year he was an instructor in the Department of Surgery at a hospital in Athens, Greece, where he also practiced.

At that time, Greece was not a very wealthy country. Few people owned automobiles. One day young Dr. Skandalakis was asked by an associate to borrow a car and go to the airport to meet a young lady who was coming from America to visit relatives in Athens and on the Island of Icaria off the coast of Turkey. That relative was his associate's niece, Mimi Cutis, of Marietta, Georgia, who eventually became Mrs. John Skandalakis.



The Skandalakis family enjoys relaxing on occasion at Sea Island. Dr. Skandalakis (left) is shown here with his wife, Mimi; daughter, Vickie Scaljon; son-in-law, Dr. Bill Scaljon; and his grandchildren, Michael and Mimi Anna Scaljon.

When the couple came to live in the United states in 1951, Dr. Skandalakis began a fellowship in surgery at Grady Memorial Hospital in Atlanta. From 1954-1957 he was a resident and chief resident at St. Joseph's Infirmary and Piedmont Hospital in Atlanta. In 1956, he was licensed by the State Board of Medical Examiners to practice medicine and surgery in Georgia. From 1956-1958 he was an instructor in anatomy at the Emory University School of Medicine, where he received a Ph.D. degree in anatomy in 1962. In 1967, he was certified by the American Board of Abdominal Surgery. From 1957-1972 he was director of Surgical and Medical Education at Piedmont Hospital. He has risen since then from assistant professor of anatomy at Emory to associate professor of anatomy, professor of gross, clinical and surgical anatomy, and clinical assistant professor of surgery, to become in 1977 Emory's first Chris Carlos Professor of Surgical Anatomy and Technique. He also has served as adjunct professor of management and health administration at Georgia State University, and as senior attending surgeon, chairman of the department of post graduate education, and president of the medical staff at Piedmont Hospital.

Dr. Skandalakis is a member of numerous professional societies, locally, nationally, and internationally, and has been the recipient of a number of honors. These include a memorial medal for underground activity awarded by the Greek government



Dr. Skandalakis (left) and Mrs. Skandalakis (second from right) are shown with their friends, Mr. and Mrs. Nickolas Chilivis, who were joint contributors of two marble busts to the law school of the University of Georgia.

for participation against the Germans and National Liberation Front (Communist) during World War II, the Golden Phoenix from the Greek government for better understanding between American and Greek people, and the Aven Citizenship Cup Award given annually by the Medical Association of Atlanta.

Dr. Skandalakis, known affectionately as "Dr. Skan" or "Dr. John," has been very active in church work, serving in many capacities over the years. In 1967, he was responsible for making financial arrangements for construction of the Greek Orthodox Church of the Annunciation on Clairmont Road in Atlanta, and was chairman of the board of directors and the building committee. He also has been the southeastern representative of the Greek Orthodox Church to the International Council of Churches, and a member of the Southern Council on International and Public Affairs. Other civic duties include his membership on the Board of Trustees of the Theater of the Stars (formerly Municipal Theater of Atlanta).

His inherent generosity extends to the Atlanta and Athens, Georgia, communities where there can be seen several pieces of sculpture which he has given as gifts to the people.

Dr. Skandalakis has held consultantships at Georgia State University in the School of Allied Health Services and Hospital Administration, and at the Yerkes Regional Primate Research Center. He has been guest editor of the MAG *Journal* Contemporary Surgery (Surgical Anatomy and Embryology Section), *Surgical Clinics of North America,* and *American Surgeon*. Between 1949 and 1982, he was author or co-author of 131 publications.

He still gets up at 3 o'clock each morning and writes for 3 hours before going to work, declaring that he requires only 6 hours of sleep.

In recent years, Dr. Skandalakis has become deeply concerned over the erosion of long-standing practical methods of teaching anatomy in the nation's medical schools, and in particular the poor anatomical knowledge of the surgical residents he sees each day. This concern has been articulated in several papers which have been printed in national medical journals.

One result of his concern over the erosion of long-standing practical methods of teaching anatomy in the nation's medical schools has been the establishment of the Center of Surgical Anatomy and Technique at the Emory University School of Medicine.

One result of his efforts has been the establishment of the Center of Surgical Anatomy and Technique at the Emory University School of Medicine. Another recent outcome is the organization of the American Association of Clinical Anatomists formed in 1983 and headquartered at Emory. The group has about 100 members and had as its first president Dr. Oliver Beahrs of the Mayo Clinic.

As a sideline to his other activities, Dr. Skandalakis is also known as a collector. His office and home are filled with interesting items he has gathered over the years, such as an impressive array of china birds. He says he likes birds and enjoys watching and feeding those around his home in northwest Atlanta "because they are so peaceful." Many people tell of his habit of giving away his valuable objects to admirers. But former students remark often that "friends are his greatest treasures," and describe him as having "a happy facility for making friends everywhere he goes and sharing with them his many blessings."

This generosity extends to the Atlanta community in general where there can be seen several large pieces of sculpture which he has given as gifts to the people. One of these, a white marble bust of Hygeia, Greek goddess of health, supported by a 6-foot marble pedestal, stands at the front entrance to the Centers for Disease Control on Clifton Road near Emory. Ordered at his own expense, the sculpture is made of marble from the same area of Greece where the original bust of Hygeia was found.

Among several pieces of statuary presented to the Woodruff Medical Center's administration building at Emory stands a statue of Hippocrates, approximately 8 feet tall and weighing 3 tons, which is a replica in Pentelic marble of a statue found on the Island of Cos. A gift from the Carlos Foundation of Atlanta, it was specially ordered by Dr. Skandalakis to honor retiring dean, Dr. Arthur P. Richardson, who served the School of Medicine at Emory from 1956-1979.

The University of Georgia in Athens also has been the recipient of statues provided by Dr. Skandalakis and Nickolas Chilivis, a former professor in the law school. Two marble busts, one of Pericles, a Greek statesman of the 5th Century B. C., and one of Demosthenes, Greek orator of the 4th Century B. C., were sculptured in Greece by Irene Chariatis from marble which came from the same mountain from which the material was extracted to build the Parthenon in Athens. They were shipped from Athens, Greece, to Athens, Georgia, and put on display in the law school.

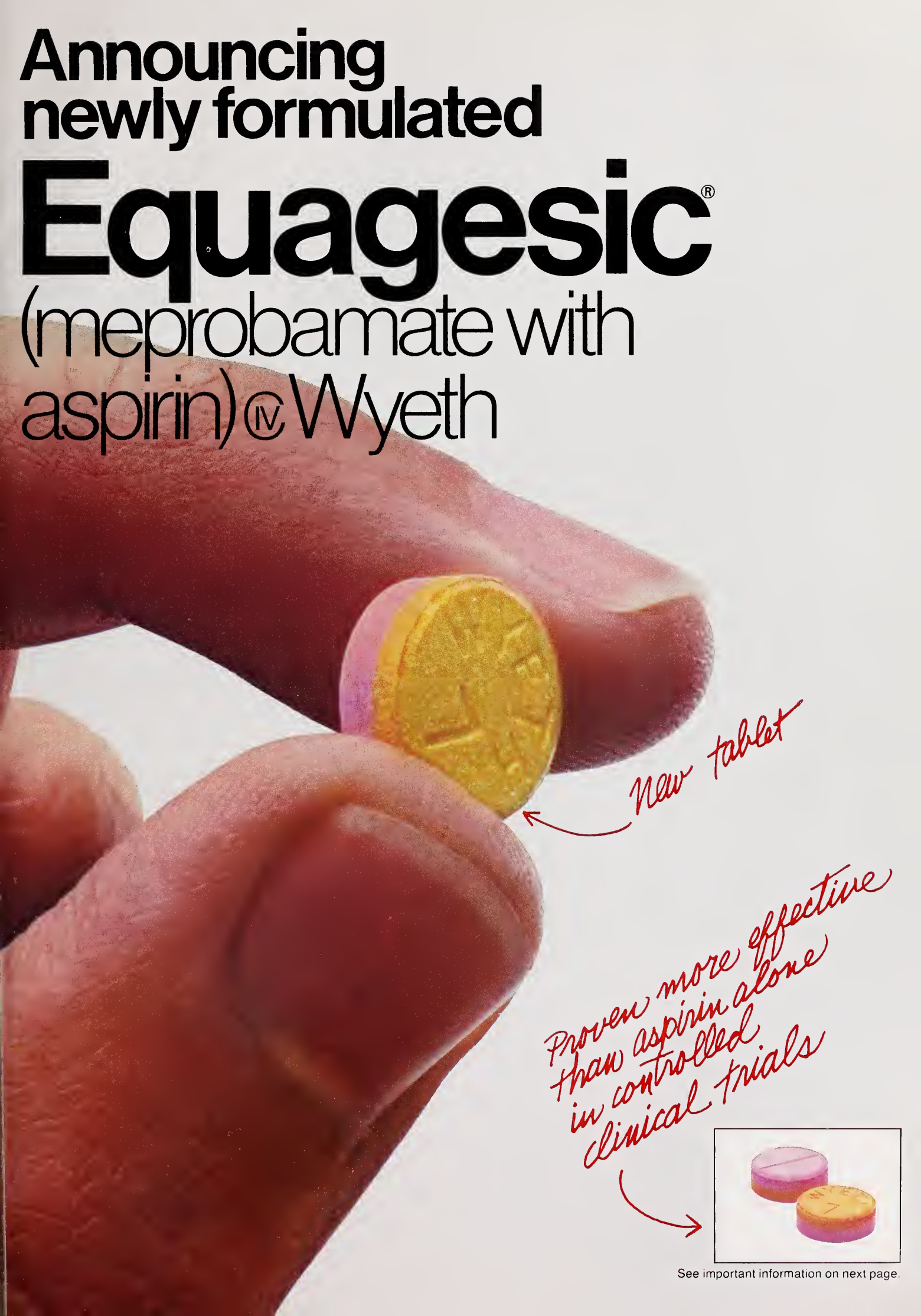
Dr. and Mrs. Skandalakis have 3 children. Their son, Lee, is a physician now in surgical training in Chicago. Another son, Mitch, is an attorney in Atlanta. Their daughter, Vickie, is married to Dr. William M. Scaljon, an Atlanta urologist, and is the mother of their two grandchildren, Michael and Mimi Anna.

Although Dr. Skandalakis has contributed much to his adopted country, he continues to be grateful to others for what he has been able to do, ending a recent interview with these words: "I don't regret coming here. There are so many opportunities in America. It opens doors to those who want to work. Anything that I accomplish here will repay in a small way the honors and abundance this land has given me."

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POTENTIALLY HAZARDOUS TASKS: Warn patients meprobamate may impair mental or physical abilities required for potentially hazardous tasks, e.g., driving or operating machinery.

ADDITIVE EFFECTS: Since CNS-suppressant effects of meprobamate and alcohol or meprobamate and other psychotropic drugs may be additive, exercise caution with patients taking more than one of these agents simultaneously.

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Meprobamate pessaa the plecental barrier. ft is preeent both in umbilicel-cord blood et or neer maternal plasme levels end in braast milk of lecteting mothars at concentretions two to four times that of matarnel plasme. Whan use of meprobemate is contemplatad in breestfeading patients, consider the drug'e higher concentrations in braast milk as comparad to maternal plasma levels.

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ADVERSE REACTIONS:
ASPIRIN: May cause epigastric discomfort, nausea, and vomiting. Hypersensitivity reactions, including urticaria, angioneurotic edema, purpura, asthma, and anaphylaxis may rarely occur. Patients receiving large doses of salicylates may develop tinnitus.

MEPROBAMATE: CNS: Drowsiness, ataxia, dizziness, slurred speech, headache, vertigo, weakness, paresthesias, impairment of visual accommodation, euphoria, overstimulation, paradoxical excitement, fast EEG activity.

GI: Nausea, vomiting, diarrhea.

CARDIOVASCULAR: Palpitation, tachycardia, various forms of arrhythmia, transient ECG changes, syncope, hypotensive crisis.

ALLERGIC OR IDIOSYNCRATIC: Milder reactions are characterized by itchy, urticarial, or erythematous maculopapular rash, generalized or confined to the groin. Other reactions include leukopenia, acute nonthrombocytopenic purpura, petechiae, ecchymoses, eosinophilia, peripheral edema, adenopathy, fever, fixed drug eruption with cross-reaction to carisoprodol, and cross-sensitivity between meprobamate/mebutamate and meprobamate/carbromal. Rare, more severe hypersensitivity reactions include hyperpyrexia, chills, angioneurotic edema, bronchospasm, oliguria, and anuria. Also, anaphylaxis, exfoliative dermatitis, stomatitis, and proctitis. Stevens-Johnson syndrome and bullous dermatitis have occurrad.

HEMATOLOGIC (SEE ALSO "ALLERGIC OR IDIOSYNCRATIC"): Agranulocytosis, aplastic anemia have been reported, although no causal relationship has been established, and thrombocytopenic purpura.

OTHER: Exacerbation of porphync symptoms.

DOSAGE AND ADMINISTRATION:
Usuel dose is one or two tablets, 3 to 4 times daily as needed for relief of pain when tension or anxiety is present. Not recommended for patients 12 years of age and under.

OVERDOSAGE:
Treatment is essentially symptomatic and supportive. Any drug remaining in the stomach should be removed. Induction of vomiting or gastric lavage may be indicated. Activated charcoal may reduce absorption of both aspirin and meprobamate. Aspirin overdosage produces usual symptoms and signs of salicylate intoxication. Observation and treatment should include management of hyperthermia, specific parenteral electrolyte therapy for ketoacidosis and dehydration, watching for evidence of hemorrhagic manifestations due to hypoprothrombinemia which, if it occurs, usually requires whole-blood transfusions. Suicidal attempts with meprobamate have resulted in drowsiness, lethargy, stupor, ataxia, coma, shock, vasomotor and respiratory collapse. Some suicidal attempts have been fatal. The following data, reported in the literature and from other sources, are not expected to correlate with each case (considering factors such as individual susceptibility and length of time from ingestion to treatment), but represent usuel ranges reported. Acute simple overdose (meprobamate elone): Death has been reported with ingestion of as little as 12 grams meprobamate and survival with as much as 40 grams.

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10-20 mg percent usually corresponds to deeper coma, requiring more intensive treatment. Some fatalities occur.

At levels greater than 20 mg percent, more fatalities than survivals can be expected.

Acute combined overdose (meprobamate with other psychotropic drugs or alcohol): Since effects can be additive, history of ingestion of a low dose of meprobamate plus any of these compounds (or of a relatively low blood or tissue level) cannot be used as a prognostic indicator.

In cases of excessive doses, sleep ensues rapidly and blood pressure, pulse, and respiratory rates are reduced to basal levels. Any drug remaining in stomach should be removed and symptomatic treatment given. Should respiration or blood pressure become compromised, respiratory assistance, CNS stimulants, and pressor agents should be administered cautiously as indicated. Diuresis, osmotic (mannitol) diuresis, peritoneal dialysis, and hemodialysis have been used successfully in removing both aspirin and meprobamate. Alkalinization of the urine increases excretion of salicylates. Careful monitoring of urinary output is necessary, and caution should be taken to avoid overhydration. Relapse and death, after initial recovery, have been attributed to incomplete gastric emptying and delayed absorption.

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Most medical care in the future is going to be delivered by organizations, and the number of patients a doctor has is going to depend on how much it costs to go to him. . . .

Forecast for Change: Health Care Organizations and the New Medical Leadership

PAUL M. ELLWOOD, M.D., ***Excelsior, Minnesota****

MORE AND MORE I find myself called upon to function as a medical-economic weather forecaster, but doctors today don't need a health weatherman to tell them which way the economic winds are blowing for medicine. They already know that the forecast is for variable change and storms. In the current health care climate, two related trends are becoming increasingly apparent:

1. Most medical care in the future is going to be delivered by organizations.
2. The number of patients a doctor has is going to depend on how much it costs to go to him or her; because third parties tend to lump together doctors and hospitals in calculating reimbursement, the cost of going to any one doctor is going to depend on how much it costs to go to other doctors on the medical staff and how much it costs to go to the hospital that doctor uses.

These trends are having two major effects. First, more and more doctors are feeling the need to affiliate with some larger organization. They want organizational strength and collective clout in order to compete successfully and retain patients. At the same time, doctors are concerned with the issue of control. They realize that affiliation in itself will not help them to achieve their goals unless they can exert a significant amount of influence within the organization they join.

There are many signs that physicians are feeling the need to affiliate, that they are realizing that they too are subject to the laws of supply and demand. As their numbers have grown — by 38% over the past 10 years — the number of patient visits per physician has fallen — from 132 visits per week in 1970 to 116 visits per week in 1980. Physicians' real income (net income adjusted for price level changes) has also declined — from $41,800 in 1970 to $38,000 in 1980 (based on 1970 dollars).

Faced with growing numbers and the apparent decline in economic power, more and more physicians have moved into group practices. In 1940, 1.2% of active physicians were in groups. By 1960, this figure had risen to 5.2%; and by 1980, to 25%. HMOs and, more recently, PPOs are also attracting increasing numbers of doctors. In early 1983, 5% of physicians were involved in PPOs, compared with 12% today.

Given the economic forces shaping the health care system today, individual practice appears to be in serious jeopardy. While solo practice is likely to become a more and more marginal form of practice, not all of its characteristics will disappear. Doctors are particularly interested in organizational arrangements that allow them to continue to practice out of their own offices and to be paid on a fee-for-service basis.

The transformation of the health industry will take place over a period of 5 to 10 years (unless we have a massive conversion of the industry into a public utility, in which case structural changes will be brought to a marked slowdown). Attempting to estimate the rate of change in the health care industry is

* Dr. Ellwood is President of InterStudy, a health policy research, education, and consulting center. This paper was presented at the MAG Leadership Conference in Atlanta in January, 1984.

difficult. At InterStudy we have been following three phenomena as predictors of change:

1. The efforts of the large hospital chains to integrate vertically (e.g., the activities of Humana throughout the U.S.)
2. The shift from conventional health insurance to preferred provider insurance. Preferred provider insurance makes full coverage available only through selected providers, with large coinsurance and deductibles required for other choices. Of particular interest are the Blues' activities in California, Michigan, and Minnesota.
3. The direction that Medicare is taking. Medicare's cap on expenditures, coupled with the growing sensitivity of insurers and purchasers of insurance to the possibility of cost shifting from Medicare, will effectively cause limitations on expenditures to be imposed on the entire health industry. If Medicare chooses to be very, very stringent with budget limits, everyone will be forced to do so. Medicare has set one other precedent: Its prospective reimbursement scheme has effectively converted every hospital with Medicare patients into an insurer, thus further speeding the integration of health insurance and health care.

In moving from speculating about the future to the present, I would like to address the question of how you as medical leaders can assume a position of strength in an industrialized and price-sensitive environment. If you plan to practice for 10 years or more, I suggest that you consider associating with some kind of medical care organization, and that you look for three fundamental characteristics in that organization. You can anticipate that the successful organization of the future is going to have the following characteristics:

1. It will be relatively large — the size of a hospital and its medical staff. It will be of a scale necessary to control all of the costs of medical care as perceived by third parties.
2. It will be capable of delivering primary care. In this way, it will be able to attract patients and control the flow of patients through every cost element of the system.
3. The successful organization will be simultaneously involved in the business of insurance and the business of medical care. Traditional health insurance will go the way of traditional solo practice, and medical care organizations will receive their money in a variety of fashions.

While it is reasonably easy to define what the health care organization of the future will look like, it is much more difficult to identify those organizations that you as Georgia physicians should join. I would like to suggest a few characteristics that you might look for that are predictive of the success of medical care organizations and of your own satisfaction in practicing in them.

1. *Quality*. A commitment to delivering high-quality services must run through the entire organization, particularly if it is not exclusively in the medical care business. In order to maintain quality, physicians should exert reasonable influence over the organization and its future. At the same time, the organization should be in a position to be very selective about the physicians who participate in it.
2. *Size*. The organization's willingness and financial ability to have the equivalent of at least 200 full-time physicians associated with it is critical to its success — e.g., its capital-generating capacity and its ability to establish satellites throughout the community.
3. *Management*. The management of successful medical enterprises is typically not flamboyant but rather quietly in the background. Successful management recognizes the critical importance of professionalism — the need of physicians to feel that they are personally responsible for their patients' well being.
4. *Cost containment*. There should be evidence that the organization can control costs. The easiest criterion to use is hospital utilization rates.
5. *Consistency*. The pieces of the organization must fit together. The incentives on which the organization is based should move the group in the same direction. Incentives should not pit doctors against hospital or primary care physicians against specialists. The incentives should move the organization in the right direction — toward becoming more selective, balanced, and congenial and toward functioning more and more like a true group practice.

One additional characteristic that I would suggest you either look for in the organization you join or nurture in yourselves is a new style of medical leadership. The hallmark of this new leadership will be the ability to recognize and accept the changes that medicine has undergone and work to strengthen the innovations that will be introduced. The new leaders will have realized that to resist change or not to become involved in shaping change serves only to accelerate change and invite others to take over the practice of medicine. They will have learned that that strategy simply does not work. The time has finally come for you to adopt a new strategy and a new style of leadership. There are opportunities for you now to really lead a profession, which although troubled, is by no means defeated.

The author explains how HCA is uniquely situated to take a leadership role in identifying the issues related to modern medical care delivery and playing a significant role in the problem-solving aspects.

Hospital Physician Dynamics

THOMAS F. FRIST, JR., M.D., *Nashville, Tennessee**

FOR THOSE OF US who are health care providers, we have entered some turbulent but exciting times. The Hospital Corporation of America (HCA) was formed in 1968, and it is amazing how much has occurred in those relatively short 15 years. However, I predict there will be far more change, more challenges, and more opportunities over the next few years. At no time in the past has there been the need that exists today to have effective communications among providers, suppliers, and consumers of health care.

HCA is uniquely situated, with its 389 hospitals, 100,000 employees, and 40,000 physicians, to take a leadership role in identifying the issues and playing a significant role in the problem-solving aspects.

Many will be threatened, particularly the "status-quoers" . . . that is, those who are constantly looking back or forward with tunnel vision.

On the other hand, those institutions and individuals who are innovative in their thinking and actions, willing to take some risks, develop contingency plans, and remain flexible will not only survive but prosper. I hasten to add that this entire process of accelerated change will continue to occur by evolution rather than revolution. There will be ample time for those who wish to adjust to do so.

The United States has the best health-care delivery system in the world, and the public will continue to expect and fund the continuation of this leadership position. The difference is that they will demand not only quality and access as in the past but also the new ingredient of holding the providers accountable for value received.

It is the latter that now poses the real threat to the former . . . that is, quality. Why? To me, one of the great strengths of our system has been the symbiotic relationships between hospitals and medical staffs. Now there is a much greater likelihood of an adversarial climate developing between these two important elements of our delivery system.

At the time HCA was founded in 1968, there was a solidifying factor drawing hospitals and physicians together. That common bond was the perceived and real threat of a socialized medical system. Over the intervening years, it was this general theme of greater government encroachment that provided a glue to hold hospitals and physicians together. We all know the myriad of examples such as CONs, PSROs, the Kennedy National Health Insurance, and Carter Cost Containment, to name a few.

From the beginning of HCA, we knew that one of the keys to our achieving success would be to facilitate this natural alliance with our medical staffs. Of course, with two of the three founders of HCA being physicians who are still active with the company today, we must admit to being a little biased on this subject. Having a father that is an internist, two younger brothers who actively practice surgery, and myself having graduated from medical school, I believe I truly understand the role of physicians in the health care delivery system and what your concerns are about the future. Today, I find myself as the only physician serving as a CEO of a Fortune 500 company, and I have resisted the pressures by many in business, finance, and government to drop the M.D. degree. When we developed our HCA missions and philosophy by which we guide this company, we clearly stated, for all to see, our commitment to our medical staffs.

In the early years of HCA it was considered a conflict of interest by the AHA for a member of the medical staff to be on the board of trustees of a hospital. "Oh, possibly ex-officio was permissible, but certainly not a significant representation." HCA

* Dr. Frist is President and Chief Executive Officer of the Hospital Corporation of America. This paper was presented at the MAG Leadership Conference in Atlanta, Jan. 14, 1984. Send reprints to Dr. Frist at HCA, P.O. Box 550, Nashville, Tennessee 37202.

took an unpopular but important stance — that meaningful representation by physicians on the board would be imperative for any well run hospital. That there are, in fact, no more potential conflicts of interest than exist for lay members of a hospital board.

Since physicians control approximately 75% of all U.S. health care expenditures, the importance of their relationship to hospitals and the U.S. health care system is vital.

Each year in our strategic planning document, we stress to our administrators the importance of perpetuating an organizational climate that is conducive to building physician relationships. We select administrators who understand the importance of this team-building approach with our medical staffs. This physician orientation in a hospital must start at the board and administrator level if it is to permeate throughout the institution. Such a climate that promotes openness, candor, mutual respect, and good lines of communication between hospital staff and the medical staff ultimately translates into quality patient care.

For many years, hospitals have considered their customers to be the patient and the physician. It has been estimated that physicians control approximately three quarters of all U.S. health care expenditures. Thus, the importance of the physician's role to hospitals and to the U.S. health care system cannot be overemphasized.

However, an important new customer has emerged that is threatening the symbiotic relationship of hospitals and physicians that has led to the world's best health care system. That additional customer of hospitals is the group purchaser of health care services in the form of major employers, Medicaid czars, and Medicare DRGs.

With this in mind, an HCA task force concluded a year-long study addressing the changing environment and how these trends might effect future relationships between hospitals and doctors.

I would like to review some of these trends and how HCA is positioning itself to benefit from them.

Physician Trends

Trend #1 — The number of physicians is increasing.

There will be 40% more physicians in the year 1990 than there are today. The ratio of physicians to population is expected to be 220 physicans per 100,000 population in 1990, and 250 in the year 2000. This compares with 170 in 1978. A recent study shows that we had a shortage of nearly 45,000 physicians in 1978, and that we will have a surplus of 145,000 in the year 2000. Granted, there will be more women physicians who may have different practices, but offsetting this will be the use of more paramedical type practitioners.

Trend #2 — The organization of medical practice is changing.

A number of changes in how medical practices are organized have occurred during the past 10 years. The most dramatic of these is the move toward the professional corporation as the predominant legal form of organization. Fewer than 20% of all physicians were incorporated as professional corporations less than 10 years ago versus almost three quarters today. This restructuring may ultimately lead to many of these professional corporations merging together to form local, regional, or national organizations.

Back when I began medical school, the primary mode of practice was solo or small single specialty groups. There was almost a stigma to joining a multi-specialty group practice.

Today, group practices are growing in popularity. HCA sees this as a very significant trend to opportunity.

Today, group practices are growing in popularity. Of all non-federal employed physicians involved in direct patient care in 1969, 16% were members of a group. This compares with 26% in 1980. HCA sees this as a very significant trend to opportunity. We have over 25 group practices of more than 20 doctors affiliated with our hospitals. The number and size of these groups are growing rapidly. The group practices are professionally managed and are becoming astute, formidable marketers of their services. They see major advantages to being associated with a multi system.

Trend #3 — Physicians are locating in new areas.

Evidence indicates that surburban locations are no longer the most popular office locations for physicians. Many rural locations are becoming popular, as evidenced by the recent Rand Corporation Study. That study showed that nearly every town of 2,500 or more people had a physician. This trend results in HCA spending more money to build small rural hospitals because these doctors are far more specialized and well trained than their predecessors. It also means fewer referrals to the urban hospitals.

Trend #4 — Physicians are faced with greater competition.

Both from other physicians as well as paramedical types, such as nurse midwives, optometrists, and chiropractitioners.

The competitive environment of health care is rapidly becoming more apparent, particularly in the physician market. In a number of communities, we are seeing physicians' practices decline.

Additionally, the physician is having to contend with competition from new corporate providers such as freestanding emergency and urgent care centers, PPOs, and HMOs.

This competition has also led some physicians to expand their offering of ancillary services in their offices or to joint venture with not-for-profit investor-owned hospitals or to develop alternative delivery centers.

At no time in the past 25 years have I seen the entrepreneurial activity of the physician so great. This increased competition among providers has serious implications for the freestanding hospitals.

Trend #5— The value of marketing is being recognized by physicians.

Those institutions, and particularly those multis, who can help the physician capture a bigger piece of the relatively shrinking health care dollar will be in a favored position.

The networking of the multis on a local, regional,and, ultimately, national basis has great implications for the practicing physician. An example would be our PriMed program designed for industry.

Trend #6 — Physician fees are increasing more slowly, and some doctors are seeing income declines.

In some parts of the country, fee increases have not been sufficient to offset a reduction in patient volume.

The government as well as the private sector will increasingly be examining ways of reducing physicians' reimbursement. As they are brought under DRG, it will be important for the multis to have in place computer linkages between the hospital and physicians' offices to assist them and, in doing so, help ourselves.

Trend #7 — Video and teleconferencing are beginning to take on growing importance for physicians. The new communication technology is opening new opportunities in remote diagnostic procedures, continuing medical education for the physicians as well as education of the consumer.

HCA is well-positioned in this area. We have our own television studios to produce and distribute video material, and we are experimenting with teleconferencing through satellite linkages to 20 of our hospitals.

Trend #8 — Physicians are dealing with a new breed of consumer — much more knowledgeable consumer. There is a definite trend towards putting these enlightened consumers back into the decision-making process.

Not only will they become more cost conscious about physicians' fees, but they will increasingly have the opportunity to do more self-diagnosis and treatment.

Trend #9 — The physicians in training today are not being prepared for the practice of tomorrow.

The high tech computer era is a threat to the traditional doctor-patient relationship. The successful physician of tomorrow must learn how to use the computer and paramedicals to provide quality health care more cost effectively.

Trend #10 — Another significant trend affecting the "role of the doctor" is the rapidly re-emerging malpractice problem.

We may well have another crisis in the next 2 years, and defensive medicine is still being practiced. There are definite potential problems as we enter the era of DRG.

Summary

The kinds of changes that physicians are facing have important implications for the relationship between physicians and hospitals. HCA is generally regarded highly by the medical profession. We have never seen ourselves as competitors with physicians, but as working partners.

This has meant providing the most well-equipped and professionally managed hospitals, the most competent support personnel. It has meant being on the cutting edge of technologic innovation and implementation. It means being creative in developing programs and systems that will successfully market our physicians. And because we are deeply conscious of the pressures physicians are under as their role changes, we have applied our resources to the dissemination of information designed specifically to assist physicians in understanding and accommodating to the new environment.

The increased competition among providers has much more serious implications for the freestanding hospitals than a multi-hospital.

The changing role of the physician in this century — his and her drive to maintain and increase income in an increasingly competitive environment — presents a major opportunity for the well run management companies.

At HCA, as we enter the era of a surplus of physicians, DRGs, competition, and alternative delivery systems, we believe our 15-year investment in building strong medical staff relations will pay us great dividends.

For a Free Diabetes Consultation, Call a Specialist.

MIST.



The University of Alabama Medical Center

The UAB Diabetes Research and Training Center offers consultations, laboratory services, and the benefits of ongoing research protocols. Laboratories include: a tissue typing laboratory which provides assays dealing with HLA typing and mixed leukocyte culture tests; an immunoparameter laboratory which tests for antibodies to pancreatic islet cells, DNA, RNA thyroid, parietal cells, adrenal cells, smooth muscle, reticulin, insulin, and for special target tissue; a human genetics marker laboratory, and a diabetes outpatient laboratory which offers a variety of clinical tests to evaluate patients with diabetes.

Additional services offered by or through the center include the following:

- **Treatment of hypoglycemia, brittle diabetes, insulin resistance, insulin allergy, mitral valve prolapse, and diabetic nerve disease.**
- **Glucose tolerance test, HBA radioimmunoassay, TSH, Prolactin, growth hormone, genetic counseling, HLA typing and lipid profiles.**
- **Biostator and insulin pumps are also available.**

The UAB Diabetes Research & Training Center is one of 60 departments, divisions and centers of the University of Alabama Medical Center accessible to you through this toll-free service.

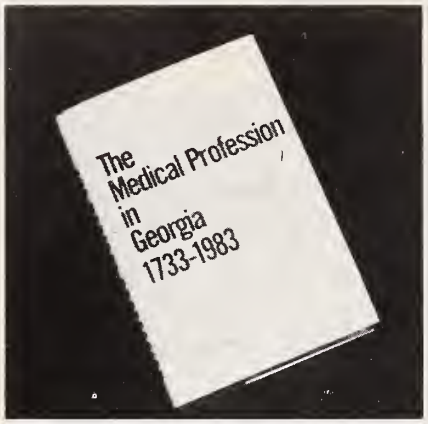
The Center welcomes physician inquiries. To speak with a physician, to consult about a patient or to refer a patient, telephone by using the toll-free MIST number. This service, including the telephone call, is free.

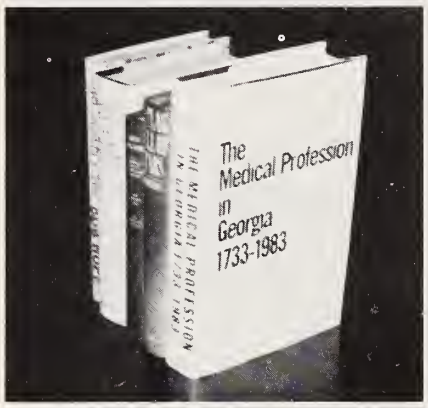
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The Medical Profession in Georgia, 1733-1983 Now Available





The MAG Auxiliary's new book, *The Medical Profession in Georgia, 1733-1983*, is now ready for distribution. It may be ordered by sending a check for $25 (made payable to the Auxiliary to the Medical Association of Georgia) to the Auxiliary office at 938 Peachtree St., NE, Atlanta, Ga. 30309, or to Evelyn Ward Gay (Mrs. Brit B., Jr.), at 911 Vistavia Circle, Decatur, Ga. 30033.

Bound in red cloth with gold stamping, and covered with a glossy jacket in white with black lettering, the book will make an ideal gift for a friend (especially a medical student), a library (either a public, hospital, or school library), or to keep for yourself. Revenues from the sale of this 400-page volume will benefit the William R. Dancy, M.D. Student Loan Fund for Georgia medical students, a project sponsored by the MAG Auxiliary.

Ridgeview Institute

Ridgeview Institute is a private, non-profit, fully accredited psychiatric hospital located twenty minutes north west of downtown Atlanta.

The hospital offers four separately housed programs in adult and adolescent chemical dependency and adult and adolescent psychiatry.

Award winning in its architectural design, Ridgeview is housed on 40 acres of land with lighted tennis and volleyball courts, swimming pool, and a fully equipped gymnasium for supervised sports and physical education programs.

Adult Chemical Dependency

The Adult Chemical Dependency Program offers a unique and innovative treatment modality that includes inpatient treatment and an emphasis on aftercare. The staff views alcohol and drug dependency as a primary disease that affects a person physically and psychologically.

The seven element program includes medical, educational, and family therapy, Alcoholics Anonymous and Narcotics Anonymous, group psychotherapy, non-chemical coping skills and spiritual counseling.

Adult Psychiatric Treatment

The Adult Psychiatric Program at Ridgeview provides specialized treatment for persons suffering from depression, anxiety, schizophrenia, manic-depressive disorders, personality disorders, and other similar dysfunctions.

Under the psychiatrist's leadership, treatment is specifically designed for each patient's particular needs in order to promote a productive return to family, job, and community as early as possible.

Adolescent Treatment Services

The Adolescent Chemical Dependency Treatment Program is based on the belief that adolescent chemical dependency is a chronic, progressive primary disease which affects the physical, psychological and sociological aspects of the life of the adolescent and his/her family.

The Adolescent Psychiatric Treatment Program provides an opportunity for building self-esteem and learning to deal with responsibility. A full range of modern therapies aid in resolving the complex emotional, behavorial, and educational difficulties of the adolescent, including individual, group, family, occupational, and recreational therapies.

Ridgeview
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3995 South Cobb Drive
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The author is a nationally recognized authority on physician-hospital contracts and compensation plans.

The Physician's View of Contracts

JOHN CLARKE, M.D., ***Oak Grove, Missouri****

TIMES ARE CHANGING. Hospitals have followed the trends of hospital diversification into alternative sources of income production and corporate reorganization and have reviewed the innovative planning models. Consequently physicians are gradually assuming a different role in their delivery of medical care. A large share of physicians will retain their autonomous model as fee-for-service practitioners. But there is an increasing number of salaried, independently contracted physicians. Many of these new positions became available as hospitals pursued the satellite or referral concept to retain their "fair share" of the market.

Suddenly, a most confusing problem has arisen: the private physician vs the contract physician. This is not to be regarded lightly. Many hospitals have had to learn bitter lessons because of varying degrees of insensitivity to this singular issue. The success of developing and maintaining salaried, contract physicians is based upon the understanding between the hospital's medical staff and the new salaried physician.

Following Dr. Paul Ellwood's pertinent and excellent comments regarding the questionable survival of solo or group practices (see article on page 299), it is quite fitting that we discuss the real inner soul of a good contract. The single thread holding a partnership intact is the quality and integrity of the contracts between physicians or between physicians and their respective corporations.

It is a new world for physicians now that 26-28% of them are contracted outside a group or partnership, and work instead for a private organization, hospital, HMO, etc. Are these physicians different? No, they are not. However, the entire medical arena has changed due to the new focus on health care costs and government involvement in the form of TEFRA, DRGs, etc.

It is not in the pervue of this discussion to reason why hospitals and others are entering this competitive field. However, suffice it to say they are, and we as physicians have become strong competitors against our own medical staffs. Many organizations are able to lure physicians from their private or group practices to become salaried, if for no other reason than for set hours and guaranteed incomes. If you are either wishing to write a better contract for your group, or have a better working contract with an organization, here are a few pertinent points for discussion.

Integrity

This needs to be foremost in all contracts. Be sure that both parties understand what is expected from the other. This is basic and should be simply stated with no innuendos or doubts. Ninety-five percent of all contractual discussion breakdowns are not because of what was said but what was *not written* into the contract.

Financial Incentives and Obligations

These must be clearly stated from the beginning. Leave room for negotiation and renegotiation, but so state that these are available in the contractual arrangements, or if these are not available, then so state clearly.

Specific Expectations of Both Parties

What is expected of the hiring physician or corporation? What are their roles? What is expected of the new physician? Do not leave anything to chance. Basically, be honest and up front. Make it simple.

* Dr. Clarke is in family practice at the Family Medicine Center of Oak Grove. He also serves as Medical Vice President of Research and Development for Research Health Services in Kansas City. This paper was presented at the MAG Leadership Conference in Atlanta in January, 1984. Send reprint requests to Dr. Clarke at 705 Broadway, Oak Grove, Missouri 64075.

Termination Clauses

These also must be clearly defined. Termination clauses should be without question, designed so that neither party is caught or compromised. Remember, no contract is better than the parties that signed it; therefore, try not to leave things unsaid.

Basic Contents of a Sound Contract

All contracts should contain very basic sections; however, these need not be legal nightmares. Most contracts can be written in six or seven pages, with all issues thoroughly delineated. The basic contents of a contract are divided into the following sections:

1. Comment of the parties involved and the identification of each party in initiation of the contract.
2. The preamble, which I regard as the concept of the hiring organization. This states the content of the contract and should be completely and simply specified.
3. The body of the contract itself.
   A. The physician's services. What is expected of the physician to be hired? Again I repeat: be simple, honest, and clear.
   B. The corporation services. What is the corporation expected to offer the contracted physician within this particular opportunity? Again, specify exactly what will be offered and what will not be serviced by the corporation.
   C. Compensation. Even though this is always the argument for most considerations, it need not be. (a) The physician compensation vs his expenses — spell these out completely. (b) The corporation compensations if any, also clearly spelled out.
   D. Terms of the contract. I recommend an open-end contract with a 90-day termination after the first 6 months. This leaves either party free to gracefully, successfully, without arbitration or difficulty get out of the contract.
   E. Termination clauses. The clauses are dependent entirely upon the organization that is hiring. They are all different. But this clause should be, and I feel very strongly about this, a noncomplete clause. This can be a full discussion of its own, but it certainly has merit for both parties.
   F. The possible purchase of the equipment and/or a possible partnership. These are issues for consideration that should be in the contract so that the prospective physician knows what his future might hold.
   G. The purchase and expense items and how they are allocated. How is the physician to pay back if ever, or if any, expense items, and if so, how will they be repaid? This includes such things as tax depreciation and redepreciation if the physician buys the equipment after a given time period. These are important issues that need to be totally discussed before written into a contract.
   H. A final caveat stating that the hospital and/or the sponsoring organizations are not involved in the *corporate practice of medicine*. This needs to be specified so that there will be no question as to the designs of the hiring corporation.

I have briefly outlined the *inner soul,* as I call it, of most contracts. These can be changed, added to, and subtracted from in many ways. However, I feel that if the basic content of the contract is adhered to, and if discussions are clear, distinct, and honest before contractual signing and writing, then most contracts will be quite successful.

There is nothing magic about a contract. Its soundness is dependent upon the integrity of those writing it and the integrity of those who sign it. If there are questions about this initial marriage, divorce is the obvious consequence. This may not be the best analogy, but it is one which I think most of us can understand.

editorial
editorial
editorial

New Help For Our Elderly Patients

SINCE MANY OF OUR ELDERLY, functionally impaired citizens in Georgia have no recourse other than to seek care in our already overcrowded nursing home and hospital facilities, it is appropriate that the Georgia General Assembly in its 1982 session passed the Community Care for the Elderly Act. Its intent was to assist functionally impaired elderly persons in living dignified and reasonably independent lives in their own homes or in the homes of relatives or caregivers through the development, expansion, reorganization, and coordination of various community-based services.

Consider the following facts as background to the Act: The Georgia Department of Medical Assistance (DMA) has reported that at least 30% of those persons who are able to support themselves and who subsequently enter nursing homes ultimately become dependent on Medicaid for their support. For fiscal year 1981, the DMA reported that the annual Medicaid cost per home health recipient was $923 as opposed to the $9,000-$10,000 annual cost for nursing home care. In fiscal 1984, an estimated 15,000 to 20,000 Georgians will seek admission to long-term care facilities and will seek certification for Medicaid to pay the cost of this care. Finally, national surveys have shown that approximately 25% of those elderly applying for nursing homes could be served in the community. Clearly, we have a responsibility to help our elderly patients obtain the most cost effective care they can, and we must also share in the responsibility to help trim the huge financial outlay by the federal government to care for our elderly.

The Georgia Department of Human Resources was mandated in the Act to plan and develop a system which will give older people a choice between institutional and community care. Initially, the program will involve only Medicaid recipients certified for admission to nursing homes or elderly persons who would be eligible for Medicaid certification within 180 days of nursing home admission. The private physician will play a key role in that he will be referring patients into the community care system. The program calls for the first services to begin in October, 1984, and community care is mandated to be statewide by July, 1985. We as private practicing physicians will be better able to serve our elderly patients through added community services and give them a choice between premature admission to nursing homes or chronic hospital stays and remaining in the community for as long as possible.

The details of this new program are outlined in the article by Dr. Ben Okel on page 281 of this *Journal*.

Edgar Woody, M.D.



Twenty-four dollars will help 40 Kenyan children recover from malnutrition.

Right now, Protestants, Catholics and Jews are working together through the Interfaith Hunger Appeal to help people in 125 countries.

With support from both business people like you, and companies like yours, Interfaith is helping these people help themselves. They're getting food to the children. And they're bringing life-giving skills to the adults. So the hungry of the world will learn to grow their own food.

Won't you ask your people to give what they can to Interfaith? Then, match their generous contribution with a corporate gift.

Simply mail in the coupon, and Interfaith Hunger Appeal will supply your business with additional information, and campaign materials.

Interfaith can't help these people without your support.

They need your help now.

"You can have my chec... Interfaith."



The Interfaith Hunger Appeal
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Giving Life to a "Living Will": What Should It Look Like? What Does It Mean? What Should Be Done With It?

ROBERT N. BERG, *Atlanta**

THIS YEAR, a new Chapter was added to Title 31 of the Official Code of Georgia Annotated: Chapter 32, which recognizes the right of a competent adult to make a written directive, known as a "Living Will," instructing his or her physician to withhold or withdraw life-sustaining procedures in the event of a terminal condition (the "Living Will Statute").

Since the enactment of the Living Will Statute generated a good deal of publicity, and since the effectuation of a Living Will can occur only after certain highly complex and difficult medical judgments are made (e.g., Does the patient have a "terminal condition"? What "life-sustaining procedures" should be withheld?), it must be expected that persons desiring to execute Living Wills will turn to their physicians — to obtain a Living Will form for them to execute *(this is especially true since the Living Will Statute prohibits hospitals, skilled nursing facilities, and other medical or health care facilities from providing Living Will forms);*[1] to receive an explanation of the medical concepts implicit in the Living Will; and, possibly, to obtain some guidance as to what to do with the Living Will after it is executed.

Accordingly, this month's Legal Page is designed to provide physicians with the information necessary for them to field questions from their patients concerning Living Wills.

The Living Will Form

The drafters of the Living Will Statute, perhaps anticipating the need for a standardized Living Will form (and, presumably intending to make it as easy and convenient as possible for persons desiring to execute Living Wills to effect their intentions), included in the Statute a mandatory form of Living Will. Under Section 31-32-3(b) of the Living Will Statute, the Living Will must be a "separate and self-contained" document in the form set out on the following page:

* Prepared at the request of the Medical Association of Georgia. Mr. Berg is an associate in the firm of Powell, Goldstein, Frazer & Murphy, General Counsel to the Association, 1100 C & S National Bank Building, Atlanta, GA 30335.

LIVING WILL

Living will made this ____ day of _____, _____ (month, year).

I, _____, being of sound mind, willfully and voluntarily make known my desire that my life shall not be prolonged under the circumstances set forth below and do declare:

1. If at any time I should have a terminal condition as defined in and established in accordance with the procedures set forth in Paragraph (10) of Code Section 31-32-2 of the Official Code of Georgia Annotated, I direct that the application of life-sustaining procedures to my body be withheld or withdrawn and that I be permitted to die;

2. In the absence of my ability to give directions regarding the use of such life-sustaining procedures, it is my intention that this living will shall be honored by my family and physician(s) as the final expression of my legal right to refuse medical or surgical treatment and accept the consequences from such refusal;

3. This will shall have no force or effect seven years from the date I signed this document as stated above; however, I understand that, if at the end of said seven years I am incapable of communicating with the attending physician, this will shall remain in effect until such time as I am able to communicate with the physician;

4. I understand that I may revoke this living will at any time;

5. I understand the full import of this living will, and I am at least 18 years of age and am emotionally and mentally competent to make this living will; and

6. If I have been diagnosed as pregnant, this living will shall have no force or effect during the course of my pregnancy.

Signed: _____

_____ *(City),* _____

(County), and _____ *(State of Residence).*

I hereby witness this living will and attest that:

1. The declarant is personally known to me and I believe the declarant to be at least 18 years of age and of sound mind;

2. I am at least 18 years of age;

3. To the best of my knowledge, at the time of the execution of this living will, I:

(A) Am not related to the declarant by blood or marriage;

(B) Would not be entitled to any portion of the declarant's estate by any will or by operation of law under the rules of descent and distribution of this state;

(C) Am not the attending physician of declarant or an employee of the attending physician or an employee of the hospital or skilled nursing facility in which declarant is a patient;

(D) Am not directly financially responsible for the declarant's medical care; and

(E) Have no present claim aganst any portion of the estate of the declarant;

4. Declarant has signed this document in my presence as above-instructed, on the date above first shown.

WITNESS:

_____

ADDRESS:

_____

WITNESS:

_____

ADDRESS:

_____

Additional witness required when living will is signed in a hospital or skilled nursing facility.

I hereby witness this living will and attest that I believe the declarant to be of sound mind and to have made this living will willingly and voluntarily.

WITNESS:

_____

Medical director of skilled nursing facility or chief of the hospital medical staff[2]

Explaining the Contents of the Living Will Form

A person desiring to execute a Living Will probably will have some general understanding of what he or she is signing — the person desires that the physician or hospital "pull the plug" if that person is inflicted with an irreversible condition which, ultimately, will be fatal. But, *when* are the person's instructions to be implemented, and *what* "plugs" are to be "pulled"?

Under the Living Will Statute, a "terminal condition" means an "incurable condition caused by disease, illness, or injury which, regardless of the application of life-sustaining procedures, would produce death."[3] Obviously, the determination of whether or not a patient has been inflicted with a "terminal condition" involves the exercise of medical judgment and must be made by the person's attending physician, rather than by the person himself or herself. Under the Living Will Statute, however, it is not the attending physician, alone, who makes the decision. Instead, the Living Will Statute requires *two* physicians, after personally examining the declarant, to certify in writing, based upon conditions found during the course of their examination, that there is no reasonable expectation for improvement in the condition of the declarant, and that death of the declarant from this condition is imminent. In practice, this procedure — effectively mandating a second opinion, *in all cases,* that the patient has a terminal condition — should provide some extra comfort to patients and their families, since implementation of the physicians' decision to withdraw life-sustaining treatment, like the terminal condition itself, is irreversible.[4]

The requirement of obtaining a confirming second opinion also is involved in the determination of "life-sustaining procedures." This term is defined in the Living Will Statute to mean "any medical procedures or interventions, which, when applied to a patient in a terminal condition, would serve only to prolong the dying process and where, in the judgment of the attending physician and a second physician, death will occur whether or not such procedures or interventions are utilized." Specifically excluded, however, from the definition of "life-sustaining procedures" are: (i) nourishment, and (ii) the administration of medication to alleviate pain or the performance of any medical procedure deemed necessary to alleviate pain.[5] Thus, a patient's written directive to "pull the plug" would not authorize the patient's attending physician to withhold food (or intravenous nourishment) or withhold pain-killing medication or treatment.

In addition to providing an explanation of the contents of the Living Will form, physicians may also be asked to provide information concerning the status of an executed Living Will. For example: For how long is a Living Will effective? What happens if I (the patient) change my mind?

Under the Living Will Statute, and as set forth above in the Living Will form, a Living Will is effective for a period of 7 years from the date on which it is executed, unless sooner revoked in an appropriate manner. However, if the patient, having executed a Living Will, becomes incapable of communicating with the attending physician, the Living Will remains in effect beyond the 7-year period, until such time as the patient is able to communicate with the attending physician.[6]

The manner by which a Living Will can be revoked is also included in the Living Will Statute. In fact, three alternative means are provided for a patient desiring to revoke a Living Will: (1) the patient, or a person in the patient's presence and acting by his or her direction, can revoke the Living Will by physically cancelling, defacing, obliterating, burning, tearing or otherwise destroying the Living Will; (2) the patient or a person acting at the patient's direction can sign and date a written revocation expressing the intent of the patient to revoke his or her Living Will (revocation in this manner becomes effective only upon communication of the revocation to the attending physician); or (3) the patient can declare his or her intent to revoke the Living Will by "any verbal or non-verbal expression" (again, revocation in this manner becomes effective only upon communication to the attending physician, either by the patient or by a person acting at the patient's direction, of the revocation).[7]

What To Do With an Executed Living Will

The Living Will Statute does not impose any requirements on the person executing the Living Will, in terms of what to do with that document after it is executed. However, since the Statute does require the attending physician to make the original Living Will a part of the patient's medical record prior to effecting a withholding or withdrawal of life-sustaining procedures from that patient,[8] it would be appropriate for a patient to provide the physician with a copy of the fully-executed Living Will, together with instructions as to the location of the original Living Will, thereby allowing the physician more easily to comply with his or her statutory obligation.[9] Also, in the event that the patient revokes the Living Will (either orally or in writing) and/or executes a new Living Will, the patient should promptly notify the physician of that occurrence.

Additionally, it may be appropriate for physicians to notify their patients from time to time to remind them of the existence of a previously executed Living Will, to request information concerning any subsequent revocation and/or the execution of a new Living Will, and, generally, to obtain confirmation that the patient's intentions have not changed. For ease of administration, this notification could be incorporated into the procedure whereby patients are notified of annual check-up dates.

Notes

1. O.C.G.A. §31-32-9(d). This Section also prohibits these facilities from preparing or offering to prepare Living Wills.
2. An additional witness — either the chief of staff of a hospital or the medical director of a skilled nursing facility — is required in the event that the declarant is a patient in a hospital or skilled nursing facility at the time the Living Will is executed. O.C.G.A. §31-32-4.
3. O.C.G.A. §31-32-2(10).
4. In fact, the General Assembly recognized the difficulty of the decisions required to be made by physicians in effectuating Living Wills: As long as the physicians, as well as the others involved in the decision-making process, act in good faith, they are immune from civil or criminal liability in acting to comply with the terms of a Living Will. O.C.G.A. §31-32-7(a).
5. O.C.G.A. §31-32-2(5).
6. O.C.G.A. §31-32-6.
7. O.C.G.A. §31-32-5(a).
8. O.C.G.A. §31-32-8(a)(4). This Section also imposes certain additional obligations on the attending physician: (a) determining that the patient is not pregnant; (b) preparing the written certification of terminal condition and placing it in the patient's medical record; and (c) making a reasonable effort to determine that the Living Will complies, *as to form,* with the requirements of the Living Will Statute.
9. Although a physician's office would seem to be a primary place for patients to execute Living Wills, it is unlikely that such will be the case in practice, since neither relatives of the declarant nor employees of the attending physician are eligible to "witness" the Living Will. O.C.G.A. §31-32-2(a).

Evaluation of the Cardiac Patient for Non-cardiac Surgery

BARRY D. SILVERMAN, M.D. and
JOHN B. NEELD, JR., M.D., *Atlanta**

Introduction

CARDIOVASCULAR COMPLICATIONS are among the most common and serious complications of anesthesia and non-cardiac operative procedures. It is important to identify before surgery those risk factors which may influence morbidity and mortality. Preoperative evaluation should include assessment of the patient's risks, selected laboratory tests, and screening for the most serious cardiovascular problems. This would permit control or correction of those factors which may contribute to anesthetic or surgical complications.

Evaluation

Evaluation of the patient should begin by taking a careful history that specifically assesses the presence of chest pain, unusual fatigue, or exertional dyspnea. These symptoms should be characterized in detail in order to identify angina pectoris or unrecognized left ventricular dysfunction with early heart failure. Physical examination should include measurement of the blood pressure, evaluation for jugular venous distention or pulmonary rales, and identification of abnormal heart sounds, particularly an S-3 gallop. The preoperative note should include each of the items listed in Table 1.

Preoperative tests should include an electrocardiogram (ECG) on any patient suspected of having heart disease. A preoperative ECG should be performed on any man over the age of 40. In Glasser's review of the literature,[1] Ferrer detected a progressive increase with age in the prevalence of abnormalities on preoperative ECGs: 11% of patients over the age of 40 had an ECG abnormality. The preoperative ECG serves to identify existing cardiac abnormalities, such as ischemia or infarction, as well as cardiac arrhythmias.

Certain cardiovascular problems represent relative contraindications to surgery. These include a myocardial infarction within the past 3 months, congestive heart failure, and severe mitral or aortic stenosis. Factors which increase the risk of surgery and which should be carefully considered include: (1) angina pectoris, (2) cyanotic heart disease, (3) mild but controlled congestive heart failure, and (4) myocardial infarction in the past 6 months. Goldman and associates[2] utilized a multivariate analysis to identify predictors of postoperative morbidity or mortality.

* Dr. Silverman is Director of Cardiology and Dr. Neeld is an anesthesiologist at Northside Hospital in Atlanta. Send reprint requests to Dr. Silverman at Northside Hospital, 1000 Johnson Ferry Rd., Atlanta, GA 30342.

Articles for this Page are sponsored and approved by the American Heart Association, Georgia Affiliate. Those wishing to contribute articles are invited to send them to Laurence O. Watkins, M.D., "Heart Page" Editor, Section of Cardiology, Dept. of Medicine, MCG, Augusta, GA 30909.

TABLE 1 — Preoperative Notes in Cardiac Patient Evaluation

1. List of patient problems.
2. Statement regarding whether cardiovascular diseases are adequately controlled.
3. List of medications.
4. Recommendations on cardiac medications which should be given on the day of surgery.
5. Statement regarding whether antibiotic prophylaxis is indicated.

TABLE 2 — Cardiac Risk Factors Associated with Postoperative Morbidity and Mortality

	*Number of Points**
1. Myocardial infarction <6 months prior to surgery	10
2. Age >70 years	5
3. S-3 gallop or jugular venous distention	11
4. Significant aortic stenosis	0
5. Any rhythm other than sinus rhythm or premature atrial contractions on last preoperative ECG	7
6. More than 5 premature ventricular contractions per minute on any previous ECG	7
7. PO_2 <60 mm Hg; PCO_2 >50 mm Hg	0
8. K <3.0 MEq/l; HCO_3 >20 MEq/l	0
9. BUN >50 mg/dl; creatinine >3.0 mg/dl	0
10. Abnormal SGOT or signs of chronic liver disease	3
11. Emergency	4
12. Intraperitoneal, thoracic, or major vascular procedure	3

**Number of Points*	*Class Indicative of Cardiovascular Complication*	*% No or Minor Complications*	*% Life-Threatening Complications*	*% Cardiac Death*
0-5	I	99	0.7	0.2
6-12	II	93	5	2
13-25	III	86	11	2
26	IV	22	22	56

They derived a point-score system in which, according to the significance of the risk factor, patients can be assigned to four classes which indicate the likelihood of cardiovascular complication (Table 2). Factors which appear to have the greatest influence include recent myocardial infarction, the presence of jugular venous distention or an S-3 gallop, and the type of surgery, intraperitoneal, and thoracic procedures being associated with the greatest risk.

Intraoperative Evaluation and Care of the Cardiac Patient

The body adjusts to surgical trauma by physiologic mechanisms which maximize intravascular volume through conservation of sodium and water. In addition, increases in cardiac output and peripheral vascular resistance maintain adequate blood pressure and organ perfusion. Cardiac patients often have a limited functional reserve and may not be able to respond appropriately to the surgical challenge. They need to be carefully examined for evidence of hypovolemia, electrolyte or acid-base abnormalities, and cardiac arrhythmias. Those patients with extremely limited reserve should have continuous intraoperative monitoring of left ventricular filling pressure, arterial pressure, and blood gases.

General anesthetic agents depress cardiac contractility: halothane, isoflurane, and enflurane have a more depressant effect than nitrous oxide.[3] Effective agents which are safe in patients with reduced cardiac contractility include droperidol, fentanyl, and the combination of nitrous oxide and pancuronium. Nitrous oxide and muscle relaxants are a *good* alternative and have a minimal myocardial depressant effect. Patients with coronary artery disease may require general anesthesia to control the sympathetic response to surgical stimulation. General anesthesia is not associated with an increase in morbidity or mortality over regional anesthesia. However, a regional block carefully administered causes a minimum of hemodynamic disturbance and would seem appropriate in a patient with severe car-

diovascular compromise. Spinal and epidural anesthesia, however, are to be avoided in patients who are hypovolemic or have a fixed cardiac output, since these anesthetic techniques are associated with peripheral vasodilation and may result in hypotension.

Patients are especially at risk for cardiac arrhythmias during the induction of anesthesia and endotrachael intubation. Intravenous thiopental is an excellent agent for induction particularly in the apprehensive patient with a history of arrhythmias. Ketamine is effective and does not stimulate catecholamine secretion but exerts a cocaine-like effect and prevents the uptake of catecholamines at postganglionic sympathetic nerve terminals. The drug is relatively contraindicated in patients who could not tolerate the tachycardia which it often produces. In patients with severe underlying heart disease, it is important to monitor the cardiac rhythm during the surgical procedure.[4]

Evaluation of the Cardiac Patient for Non-Cardiac Surgery

Coronary Artery Disease

Coronary atherosclerotic heart disease is a major cause of perioperative morbidity and mortality. Tarhan et al.[5] noted a 37% reinfarction rate and a 50% mortality rate in patients operated on within 3 months of a myocardial infarction. The reinfarction rate was 16% when the operation was performed 3-6 months after the myocardial infarction and 5% thereafter. Topkins and Artusio[6] found a 55% reinfarction rate in patients with previous myocardial infarction when surgery was performed in less than 6 months. The reinfarction rate fell to 6% in the second year, and after the third year, it was only 1%. Goldman[7] reported a similar finding and suggested that patients with remote myocardial infarctions (i.e., interval since infarction greater than 12 months) were at no greater risk than those who had never had an infarction. Patients with stable angina pectoris are probably at increased risk of myocardial infarction. In his review of the literature, Glasser[1] found a surgical mortality varying from 0 to 17%, with the overall mortality for the combined series being about 9%.

Valvular Heart Disease

The presence of aortic stenosis confers the greatest risk of surgical morbidity and mortality on patients exposed to general anesthesia. These patients do not tolerate cardiac arrhythmias and hypotension. This is also true of hypertrophic cardiomyopathy. Patients with mitral stenosis have limited, often fixed, cardiac output and require special monitoring to avoid hypotension and volume overload.

Antibiotic prophylaxis for endocarditis should be considered in patients with valvular heart disease. Patients undergoing any procedure that might result in bacteremia should receive prophylactic antibiotics. These include dental procedures, upper respiratory tract surgery, gastrointestinal and genitourinary surgery, and instrumentation.[8] A regimen suggested by the American Heart Association is recommended. Special care should be given to those patients with prosthetic heart valves as they are at particularly high risk for developing endocarditis.

Cardiac Drugs

Digitalis Glycosides

Digitalis preparations frequently cause toxicity in the postoperative period. These drugs have a low therapeutic index, and changes in their absorption and excretion may produce toxicity. Patients should be closely monitored for cardiac arrhythmias, central nervous system or visual disturbances, dementia, or nausea and vomiting. Inadequate use of digitalis glycosides in the postoperative period may result in an increase in the heart rate in patients with atrial fibrillation or the development of pulmonary edema.

Beta-blocking Agents

Beta-blocking agents are used in the treatment of hypertension, angina pectoris,

and cardiac arrhythmias. When first introduced, they were discontinued prior to surgical procedures because it was felt they might potentiate the myocardial depressant effect of anesthetics, interfere with cardiac responsiveness to hypovolemia or bradycardia, and precipitate bronchospasm during the surgical procedure. However, subsequent studies have suggested improved outcomes when beta-blocking therapy is maintained. Treatment of the underlying cardiovascular disorder appears to be more important in preventing surgical complications than possible side effects of these drugs.[9]

Nitroglycerin and Nitrate Compounds

Nitrates are now routinely used in patients undergoing surgical procedures with known or suspected ischemic heart disease. Glasser et al.[1] have suggested guidelines for nitrate therapy in the surgical setting. These include checking for postural hypotension prior to surgery, avoiding the use of nitrates when hypovolemia is present, avoiding abrupt discontinuation of a long-acting nitrate, and avoiding the placement of nitroglycerin ointment over the surgical sites. If these recommendations are followed, nitrates may be used effectively to prevent myocardial ischemic complications that would otherwise occur during surgical procedures.

Calcium Channel Blocking Agents

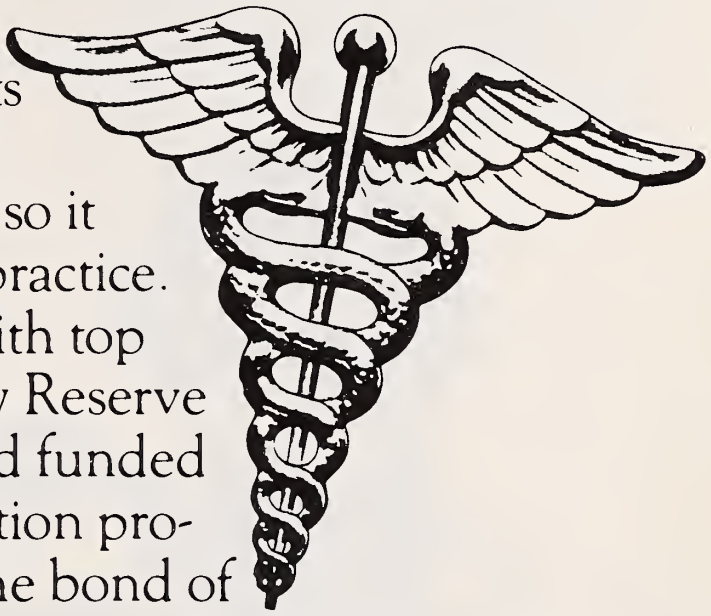
Calcium channel blockers are excellent agents in the treatment of ischemic heart disease and are valuable during the intraoperative and postoperative periods. Like the nitrate compounds, they are potent peripheral vasodilators and should be avoided when there is evidence of hypovolemia. Patients should be evaluated for postural hypotension prior to surgery. The concomitant use of beta-blocking agents and Verapamil may precipitate heart failure in patients with pre-existing left ventricular dysfunction. This combination should be avoided in surgical patients.

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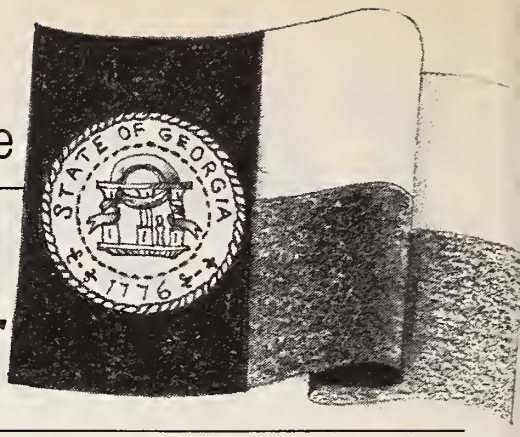


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Dr. Crawford W. Long

One of the most important discoveries in medicine was the use of ether in surgical procedures, and its revelation was delayed because of the inordinate modesty of Dr. Crawford W. Long, its first successful user.

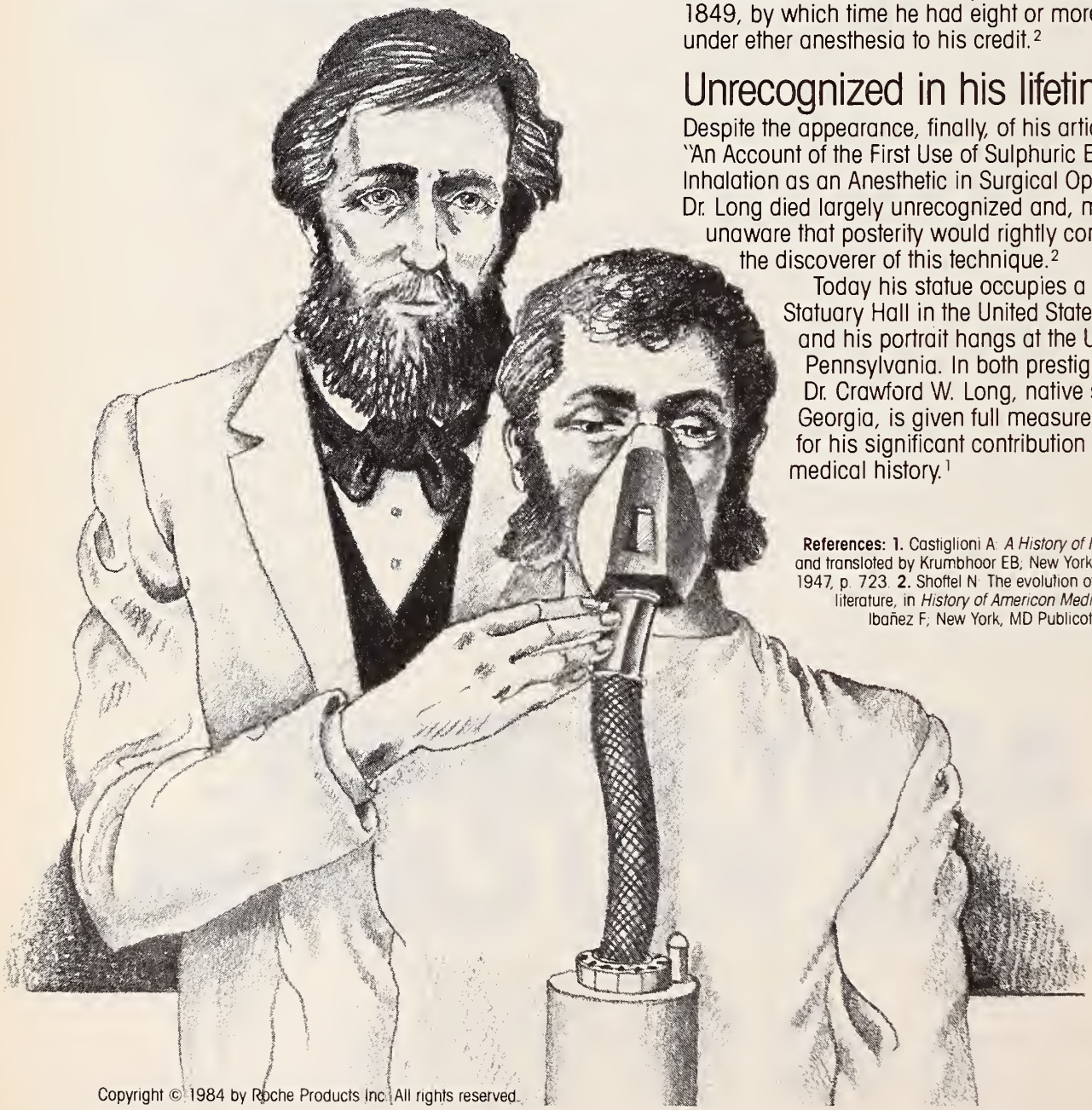
A simple country practitioner in Jefferson, Georgia, Dr. Long had little surgical experience when, on March 30, 1842, he experimented with the use of sulfuric ether as an anesthetic in the surgical removal of a small septic tumor from the neck of a patient. The patient, James Venable, reported feeling no pain during the incision and removal proceedings, and soon recovered.[1,2]

Pleased by the results of surgery under anesthesia, Dr. Long continued to use ether in surgery and obstetrics. Recognition for his accomplishment was limited, however, because he did not publish his discovery until 1849, by which time he had eight or more operations under ether anesthesia to his credit.[2]

Unrecognized in his lifetime

Despite the appearance, finally, of his article titled "An Account of the First Use of Sulphuric Ether by Inhalation as an Anesthetic in Surgical Operations," Dr. Long died largely unrecognized and, most assuredly, unaware that posterity would rightly consider him the discoverer of this technique.[2]

Today his statue occupies a place in Statuary Hall in the United States Capitol, and his portrait hangs at the University of Pennsylvania. In both prestigious locations, Dr. Crawford W. Long, native son of Georgia, is given full measure of respect for his significant contribution to medical history.[1]



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Limbitrol also has a rapid onset of action which may lead to greater patient compliance. In a multicenter study, patients taking Limbitrol experienced 62% of their overall improvement within the first week of therapy.[2]

In another multicenter study,[3] the following symptoms associated with anxious depression were significantly reduced during the first two weeks of therapy:

- ☐ Headache—79%
- ☐ Early insomnia—91%
  Middle insomnia—87%
  Late insomnia—89%
- ☐ Gastrointestinal upset—73%

In two multicenter studies, only 1.9% of Limbitrol patients experienced cardiovascular side effects.[3]

Patients should be cautioned about the combined effects with alcohol or other CNS depressants and about activities requiring complete mental alertness such as operating machinery or driving a car.

References: 1. Rickels K: Drug treatment af anxiety, in *Psychapharmacalagy in the Practice af Medicine,* edited by Jarvik ME; New York, Appletan-Century-Crafts, 1977, p. 316. **2.** Feighner JP *et al: Psychapharmacalagy 61:* 217-229, Mar 1979. **3.** Data an file, Haffmann-La Rache Inc., Nutley, NJ.

In moderate depression and anxiety

Limbitrol® IV

Tablets 5-12.5 each containing 5 mg chlordiazepoxide and 12.5 mg amitriptyline (as the hydrochloride salt)
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Please see summary of product information on following page.

LIMBITROL® Tablets Ⓝ Tranquilizer–Antidepressant

Before prescribing, please consult complete product information, o summary of which follows:

Indications: Relief of moderate to severe depression associated with moderate to severe anxiety.

Contraindications: Known hypersensitivity to benzodiazepines or tricyclic antidepressants. Do not use with monoamine oxidase (MAO) inhibitors or within 14 days following discontinuation of MAO inhibitors since hyperpyretic crises, severe convulsions and deaths have occurred with concomitant use; then initiate cautiously, gradually increasing dosage until optimal response is achieved. Contraindicated during acute recovery phase following myocardial infarction.

Warnings: Use with great care in patients with history of urinary retention or angle-closure glaucoma. Severe constipation may occur in potients taking tricyclic antidepressonts and anticholinergic-type drugs. Closely supervise cardiovascular patients. (Arrhythmias, sinus tachycardio and prolongotion of conduction time reported with use of tricyclic antidepressants, especially high doses. Myocardial infarction and stroke reported with use of this class of drugs.) Caution patients about possible combined effects with alcohol and other CNS depressants and againsf hazardous occupations requiring complete mental alertness (*e.g.*, operating machinery, driving).

***Usage in Pregnancy:* Use of minor tranquilizers during the first trimester should olmost olways be ovoided becouse of increosed risk of congenitol molformotions os suggested in severol studies. Consider possibility of pregnoncy when instituting therapy; odvise patients to discuss therapy if they intend to or do become pregnant.**

Since physical ond psychological dependence to chlordiazepoxide have been reported rarely, use caution in administering Limbitrol to oddiction-prone individuals or those who might increase dosage; withdrawol symptoms following discontinuation of either component alone have been reported (nausea, headache and malaise for amitriptyline; symptoms [including convulsions] similar to those of barbiturate withdrawal for chlordiazepoxide).

Precoutions: Use with coution in patients with o history of seizures, in hyperthyroid patients or those on thyroid medication, and in patients with impaired renal or hepatic function. Because of the possibility of suicide in depressed patients, do not permit easy access to large quontities in these potients. Periodic liver function tests and blood counts ore recommended during prolonged treotment. Amitriptyline component may block action of guanethidine or similar antihypertensives. Concomitant use with other psychotropic drugs has not been evaluated; sedative effects may be odditive. Discontinue several doys before surgery. Limit concomitant administration of ECT to essential treatment. See Warnings for precautions about pregnancy. Limbitrol should not be taken during the nursing period. Not recommended in children under 12. In the elderly and debilitated, limit to smallest effective dosage to preclude otoxia, oversedation, confusion or anticholinergic effects.

Adverse Reactions: Most frequently reported are those associated with either component alone: drowsiness, dry mouth, constipation, blurred vision, dizziness and bloating. Less frequently occurring reactions include vivid dreams, impotence, tremor, confusion and nosal congestion. Many depressive symptoms including onorexio, fatigue, weakness, restlessness and lethargy have been reported as side effects of both Limbitrol and amitriptyline. Gronulocytopenia, jaundice and hepatic dysfunction have been observed rarely.

The following list includes adverse reactions not reported with Limbitrol but requiring consideration because they have been reported with one or both components or closely related drugs:

Cardiovascular: Hypotension, hypertension, tachycardia, palpitations, myocardial inforction, arrhythmias, heart block, stroke.

Psychiatric: Euphoria, apprehension, poor concentration, delusions, hallucinations, hypomania and increased or decreased libido.

Neuralogic: Incoordinotion, ataxia, numbness, tingling and paresthesias of the extremities, extrapyramidal symptoms, syncope, chonges in EEG patterns.

Antichalinergic: Disturbance of accommodation, paralytic ileus, urinary retention, dilatation of urinary tract.

Allergic: Skin rash, urticaria, photosensitization, edema of face and tongue, pruritus.

Hematalagic: Bone marrow depression including agranulocytosis, eosinophilia, purpura, thrombocytopenia.

Gastrointestinal: Nousea, epigastric distress, vomiting, anorexia, stomatitis, peculiar taste, diarrhea, black tongue.

Endacrine: Testicular swelling and gynecomastia in the male, breast enlargement, galactorrhea and minor menstrual irregularities in the female, elevation and lowering of blood sugar levels, and syndrome of inappropriate ADH (antidiuretic hormone) secretion.

Other: Headache, weight gain or loss, increased perspiration, urinary frequency, mydriasis, jaundice, alopecia, parotid swelling.

Overdosoge: Immediately hospitalize patient suspected of having taken an overdose. Treatment is symptomatic and supportive. I.V. administration of 1 to 3 mg physostigmine salicylate has been reported to reverse the symptoms of amitriptyline poisoning. See complete product information for manifestation and treatment.

Dosoge: Individualize according to symptom severity and patient response. Reduce to smallest effective dosage when satisfactory response is obtained. Larger portion of daily dose may be taken at bedtime. Single *h.s.* dose may suffice for some patients. Lawer dosages are recommended for the elderly.

Limbitrol 10-25, initial dosage of three or four tablets daily in divided doses, increased up to six tablets or decreased to two tablets daily os required. Limbitrol 5-12.5, initial dosage of three or four tablets daily in divided doses, for patients who do not tolerate higher doses.

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References:

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BRIEF SUMMARY

PRDCARDIA® (nifedipine) **CAPSULES** For Dral Use

INDICATIDNS AND USAGE: I. Vasospastic Angina: PROCARDIA (nifedipine) is indicated for the management of vasospastic angina confirmed by any of the following criteria: 1) classical pattern of angina at rest accompanied by ST segment elevation, 2) angina or coronary artery spasm provoked by ergonovine, or 3) angiographically demonstrated coronary artery spasm. In those patients who have had angiography, the presence of significant fixed obstructive disease is not incompatible with the diagnosis of vasospastic angina, provided that the above criteria are satisfied. PROCARDIA may also be used where the clinical presentation suggests a possible vasospastic component but where vasospasm has not been confirmed, e.g., where pain has a variable threshold on exertion or in unstable angina where electrocardiographic findings are compatible with intermittent vasospasm, or when angina is refractory to nitrates and or adequate doses of beta blockers.

II. Chronic Stable Angina (Classical Effort-Associated Angina): PROCARDIA is indicated for the management of chronic stable angina (effort-associated angina) without evidence of vasospasm in patients who remain symptomatic despite adequate doses of beta blockers and or organic nitrates or who cannot tolerate those agents.

In chronic stable angina (effort-associated angina) PROCARDIA has been effective in controlled trials of up to eight weeks duration in reducing angina frequency and increasing exercise tolerance, but confirmation of sustained effectiveness and evaluation of long-term safety in those patients are incomplete.

Controlled studies in small numbers of patients suggest concomitant use of PROCARDIA and beta blocking agents may be beneficial in patients with chronic stable angina, but available information is not sufficient to predict with confidence the effects of concurrent treatment, especially in patients with compromised left ventricular function or cardiac conduction abnormalities. When introducing such concomitant therapy, care must be taken to monitor blood pressure closely since severe hypotension can occur from the combined effects of the drugs. (See Warnings.)

CONTRAINDICATIDNS: Known hypersensitivity reaction to PROCARDIA.

WARNINGS: Excessive Hypotension: Although in most patients, the hypotensive effect of PROCARDIA is modest and well tolerated, occasional patients have had excessive and poorly tolerated hypotension. These responses have usually occurred during initial titration or at the time of subsequent upward dosage adjustment, and may be more likely in patients on concomitant beta blockers.

Severe hypotension and or increased fluid volume requirements have been reported in patients receiving PROCARDIA together with a beta blocking agent who underwent coronary artery bypass surgery using high dose fentanyl anesthesia. The interaction with high dose fentanyl appears to be due to the combination of PROCARDIA and a beta blocker, but the possibility that it may occur with PROCARDIA alone, with low doses of fentanyl, in other surgical procedures, or with other narcotic analgesics cannot be ruled out. In PROCARDIA treated patients where surgery using high dose fentanyl anesthesia is contemplated, the physician should be aware of these potential problems and, if the patient's condition permits, sufficient time (at least 36 hours) should be allowed for PROCARDIA to be washed out of the body prior to surgery.

Increased Angina: Occasional patients have developed well documented increased frequency, duration or severity of angina on starting PROCARDIA or at the time of dosage increases. The mechanism of this response is not established but could result from decreased coronary perfusion associated with decreased diastolic pressure with increased heart rate, or from increased demand resulting from increased heart rate alone.

Beta Blocker Withdrawal: Patients recently withdrawn from beta blockers may develop a withdrawal syndrome with increased angina, probably related to increased sensitivity to catecholamines. Initiation of PROCARDIA treatment will not prevent this occurrence and might be expected to exacerbate it by provoking reflex catecholamine release. There have been occasional reports of increased angina in a setting of beta blocker withdrawal and PROCARDIA initiation. It is important to taper beta blockers if possible, rather than stopping them abruptly before beginning PROCARDIA.

Congestive Heart Failure: Rarely, patients, usually receiving a beta blocker, have developed heart failure after beginning PROCARDIA. Patients with tight aortic stenosis may be at greater risk for such an event.

PRECAUTIDNS: General: Hypotension: Because PROCARDIA decreases peripheral vascular resistance, careful monitoring of blood pressure during the initial administration and titration of PROCARDIA is suggested. Close observation is especially recommended for patients already taking medications that are known to lower blood pressure. (See Warnings.)

Peripheral edema: Mild to moderate peripheral edema, typically associated with arterial vasodilation and not due to left ventricular dysfunction, occurs in about one in ten patients treated with PROCARDIA. This edema occurs primarily in the lower extremities and usually responds to diuretic therapy. With patients whose angina is complicated by congestive heart failure, care should be taken to differentiate this peripheral edema from the effects of increasing left ventricular dysfunction.

Drug interactions: Beta-adrenergic blocking agents: (See Indications and Warnings.) Experience in over 1400 patients in a non-comparative clinical trial has shown that concomitant administration of PROCARDIA and beta-blocking agents is usually well tolerated, but there have been occasional literature reports suggesting that the combination may increase the likelihood of congestive heart failure, severe hypotension or exacerbation of angina.

Long-acting nitrates: PROCARDIA may be safely co-administered with nitrates, but there have been no controlled studies to evaluate the antianginal effectiveness of this combination.

Digitalis: Administration of PROCARDIA with digoxin increased digoxin levels in nine of twelve normal volunteers. The average increase was 45%. Another investigator found no increase in digoxin levels in thirteen patients with coronary artery disease. In an uncontrolled study of over two hundred patients with congestive heart failure during which digoxin blood levels were not measured, digitalis toxicity was not observed. Since there have been isolated reports of patients with elevated digoxin levels, it is recommended that digoxin levels be monitored when initiating, adjusting, and discontinuing PROCARDIA to avoid possible over- or under-digitalization.

Carcinogenesis, mutagenesis, impairment of fertility: When given to rats prior to mating, nifedipine caused reduced fertility at a dose approximately 30 times the maximum recommended human dose.

Pregnancy: Category C. Please see full prescribing information with reference to teratogenicity in rats, embryotoxicity in rats, mice and rabbits, and abnormalities in monkeys.

ADVERSE REACTIDNS: The most common adverse events include dizziness or light-headedness, peripheral edema, nausea, weakness, headache and flushing each occurring in about 10% of patients, transient hypotension in about 5%, palpitation in about 2% and syncope in about 0.5%. Syncopal episodes did not recur with reduction in the dose of PROCARDIA or concomitant antianginal medication. Additionally, the following have been reported: muscle cramps, nervousness, dyspnea, nasal and chest congestion, diarrhea, constipation, inflammation, joint stiffness, shakiness, sleep disturbances, blurred vision, difficulties in balance, dermatitis, pruritus, urticaria, fever, sweating, chills and sexual difficulties. Very rarely introduction of PROCARDIA therapy was associated with an increase in anginal pain, possibly due to associated hypotension.

In addition, more serious adverse events were observed, not readily distinguishable from the natural history of the disease in these patients. It remains possible, however, that some or many of these events were drug related. Myocardial infarction occurred in about 4% of patients and congestive heart failure or pulmonary edema in about 2%. Ventricular arrhythmias or conduction disturbances each occurred in fewer than 0.5% of patients.

Laboratory Tests: Rare, mild to moderate, transient elevations of enzymes such as alkaline phosphatase, CPK, LDH, SGOT, and SGPT have been noted, and a single incident of significantly elevated transaminases and alkaline phosphatase was seen in a patient with a history of gall bladder disease after about eleven months of nifedipine therapy. The relationship to PROCARDIA therapy is uncertain. These laboratory abnormalities have rarely been associated with clinical symptoms. Cholestasis, possibly due to PROCARDIA therapy, has been reported twice in the extensive world literature.

HDW SUPPLIED: Each orange, soft gelatin PROCARDIA CAPSULE contains 10 mg of nifedipine. PROCARDIA CAPSULES are supplied in bottles of 100 (NDC 0069-2600-66), 300 (NDC 0069-2600-72), and unit dose (10x10) (NDC 0069-2600-41). The capsules should be protected from light and moisture and stored at controlled room temperature 59° to 77°F (15° to 25°C) in the manufacturer's original container.

More detailed professional information available on request.

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Quotes from an unsolicited letter received by Pfizer from an angina patient. While this patient's experience is representative of many unsolicited comments received, not all patients will respond to Procardia nor will they all respond to the same degree.

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"I have been able to do volunteer work...and feel needed and useful once again."

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Side effects are usually mild (most frequently reported are dizziness or lightheadedness, peripheral edema, nausea, weakness, headache and flushing, each occurring in about 10% of patients, transient hypotension in about 5%, palpitation in about 2% and syncope in about 0.5%).



for the varied faces of angina

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*Procardia is indicated for the management of:
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2) Angina where the clinical presentation suggests a possible vasospastic component.
3) Chronic stable angina without evidence of vasospasm in patients who remain symptomatic despite adequate doses of beta blockers and/or nitrates or who cannot tolerate these agents. In chronic stable angina (effort-associated angina) PROCARDIA has been effective in controlled trials of up to eight weeks' duration in reducing angina frequency and increasing exercise tolerance, but confirmation of sustained effectiveness and evaluation of long-term safety in these patients are incomplete.

Please see PROCARDIA *brief summary on adjoining page.*

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J-4044 January 1984

The Role of Adjuvant Radiation Therapy in Adenocarcinoma of the Rectum and Rectosigmoid

CHARLES M. MENDENHALL, M.D., *Albany**

Colorectal cancer ranks second to lung cancer as the leading cause of death from cancer in the United States. Approximately 60% of the lesions occur in the rectum or rectosigmoid.[1] The mainstay of treatment is complete surgical excision of the primary lesion and regional lymphatics. Despite better methods of detection, survival rates have not changed significantly over the past 40 years.

The incidence of local-regional recurrence following an apparent curative resection is high and varies with the definition of local-regional recurrence, the length of time that the patients are followed, and the diligence with which one looks for such a recurrence. Local-regional recurrence is defined as those sites of recurrent tumor which could reasonably be affected by adjuvant irradiation and would include areas contiguous to the operative bed and sites that could be seeded by the tumor at the time of surgery, such as the abdominal incisions. Approximately 50% of the patients in whom a local-regional recurrence develops die without ever having evidence of distant metastases.[2] If local-regional recurrence could be prevented, theoretically a significant number of patients could be cured. In addition, local-regional recurrence is often a source of severe morbidity, so that even in patients who develop distant metastasis, measures that would diminish the incidence of local-regional recurrence would significantly improve their quality of life.

The management of such recurrence either with surgery or irradiation has been disappointing.[3, 4, 11] Cures are rare, and most series dealing with palliative radiotherapy show significant alleviation of symptoms in only 50% of cases, usually lasting for less than 6 months.

Prognostic factors which are related to the incidence of local-regional recurrence include extension through the bowel wall, involvement of regional lymph nodes, length of the lesion, and degree of histologic differentiation. There are conflicting reports concerning the relationship of distance from anal verge and type of surgical procedure performed to the incidence of local-regional recurrence.[2, 5-10, 22] The incidence of local-regional recurrence has been shown to correlate well with the pathologic stage of the lesion.[2]

The Astler-Coller modification of the Dukes staging system will be used in this paper and is presented on the following page:[19]

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* Dr. Mendenhall is a radiation therapist at Phoebe Putney Memorial Hospital, P.O. Drawer 1828, Albany, GA 31703. Send reprint requests to him.

Prepared at the request of the Georgia Division, American Cancer Society. Others wishing to contribute papers to this Page are invited to send them to T. Gray Fountain, MD, 910 N. Jefferson, Albany, GA 31708.

Stage

CIS	Carcinoma in situ
A	Limited to mucosa
B1	Extending into (not through) muscularis mucosa
B2	Through entire bowel wall, negative nodes
C1	Limited to bowel wall, positive nodes
C2	Through wall, positive nodes
D	Distant metastasis

Surgery Alone

The incidence of local-regional recurrence following treatment with surgery alone has been well documented by a number of authors (Table 1). It is evident that a significant proportion of patients experience local-regional recurrence, particularly patients with stage B2 and C disease.

TABLE 1 — Incidence of Local-Regional Recurrence After Surgery Alone

Author Institution	*Site*	*Minimum Follow-up*	*Def. of Local Recurrence*	*A*		*B*		*C*		*TOTAL*
				CIS/A	*A/B1*	*B1*	*B2*	*C1*	*C2*	
Mendenhall et al.*[2] Univ. of Fla.	R,RS	5 yr.	P,W,I	0/19	—	6/23 23%	12/45 27%	12/24 50%	11/29 38%	41/140 29%
Rao et al.[11] South. Calif. Permanente	R,RS, S	5 yr.	P,W	1/14 7%	—	8/48 12%	30/87 34%	13/26 50%	20/29 69%	72/204 35%
Malcolm et al[7] Peter Bent Brigham Hosp.	R,RS,S	5 yr.	P,W	1/16 6%	—	6/62 10%	12/36 33%	5/20 25%	9/22 41%	33/156 21%
Walz et al.[10] Washington Univ.	R,RS	5 yr.	P	2/15 13%	—	0/22	7/50 14%	2/8 25%	15/48 31%	26/143 18%
Gilbertson et al.[12]† Univ. of Minn.	R	10 yr.	P	—	9/29 31%	—	6/20 30%	26/57 46%	— —	41/106 39%
Veazey & McBride[13] M. D. Anderson Hosp.	R	5 yr.	P	—	3/37 8%	—	6/27 22%	17/58 29%	—	26/122 21%
Rich et al.[14] Mass. Gen. Hosp.	R	5 yr.	P	3/39 8%	—	18/59 31%	—	22/44 50%	—	43/142 30%
Pilipshen et al.[15] Memorial Sloan Kettering	R	(not stated)	P	—	18/133 14%	—	32/111 29%	—	55/138 40%	105/382 27%

R = Rectum; RS = Rectosigmoid; P = Pelvis; W = Wound or peritoneal seeding
I = Inguinal nodes; S = Sigmoid
* No exclusions; includes patients dead of intercurrent disease and treatment complications in the denominator in order to allow comparison with other reports.
† Second-look operations.

Adjunctive Radiation Therapy

Adjunctive radiation therapy can be given preoperatively, postoperatively, or in the so-called "sandwich technique" (pre- and post-operative treatment). The advantages and disadvantages of pre- versus postoperative radiotherapy (RT) are listed below.

	Advantages	*Disadvantages*
Pre-op RT:		
	Reduce the size of the lesion to improve resectability.	Inclusion of early stage lesions.
	Decreased dissemination of tumor cells by surgical manipulation.	Slight delay in wound healing.
	Improved survival.	Inclusion of patients with clinically inapparent distant metastases.
	Decreased incidence of local-regional recurrences.	
Post-op RT:		
	Decreased incidence of local-regional recurrences.	No documented improvement in survival.
	Allows accurate pathologic staging.	Higher rate of radiation-related complications (i.e., small bowel obstruction).
		Does not prevent dissemination of tumor cells at the time of surgery.
		Larger volume irradiated.
		High irradiation dose necessary.

The "sandwich technique," which combines low dose preoperative irradiation and high dose postoperative irradiation in those patients thought to be at high risk for local-regional recurrence, has the same disadvantages as postoperative irradiation.

Roswit et al.[16] published the results of the National Veterans Administration's randomized prospective trial comparing results in patients treated with surgery alone for rectal or rectosigmoid lesions versus those in patients receiving 2000-2500 rads to the pelvis prior to surgery. In the group of patients undergoing abdominoperineal resection, a 13% improvement in survival at 5 years was noted in the irradiated group. Local recurrences were significantly lessened in the preoperatively treated group, 29% versus 40%. The radiation dose of 2000-2500 rads employed in this study is relatively low compared to preoperative regimens utilized at the present time (4500-5000 rads) and explains the still high 29% local recurrence rate. Surprisingly, no survival benefit was noted in patients undergoing an anterior resection.

Stevens et al.[17] from the University of Oregon reported a series of patients treated preoperatively with doses of 5000 rads or greater. In the group of patients with clinically resectable lesions at presentation, the 5-year survival was 53% compared to 38% for a matched group of historic controls treated with surgery alone. No local recurrences were noted in preoperatively treated patients who underwent "curative" resections. Of 40 irradiated patients who were initially unresectable, 20 were found to be resectable following preoperative radiation therapy.

Preoperative irradiation has been used at the University of Florida since 1975.[18] Sixty-four patients with clinically resectable adenocarcinoma of the rectum and rectosigmoid underwent preoperative irradiation and complete resection from July, 1975, through December, 1981. Doses initially were 3000 to 3500 rads at 180 rads per fraction and have since been increased to 4500 rads over 5 weeks. Most patients have tolerated irradiation with minimal or no side effects. Surgery was performed 4 to 6 weeks following irradiation and thus far, there has been no increase in postoperative complications except for minimal delay in the healing of the perineal incision in patients undergoing an abdominoperineal resection. Thirty patients have been followed for a minimum of 5 years and, when compared to historic controls treated with surgery alone, a significant decrease in local-regional recurrence has been noted, as well as an improvement in the absolute and disease-free survival rates.

The use of postoperative radiotherapy is being studied at a number of institutions. Romsdahl and Withers[20] from M. D. Anderson Hospital compared results obtained in a group of patients with stage B2 and C lesions who received 5000 rads postoperatively to the results obtained in historic controls treated with surgery alone. With a median follow-up of 34 months, a reduction in local recurrences was evident. Follow-up was too short and the number of patients too few for a meaningful analysis of survival. The incidence of local-regional recurrence by stage is as follows:

Stage	*Post-Op RT*	*Surgery Alone*
+B2	1/18 (6%)	16/90 (18%)
C1	0/ 3	1/8 (13%)
C2	3/33 (10%)	18/52 (34%)
* B3, C3	1/8 (12%)	8/14 (62%)

+ Astler-Coller Modification of Dukes Staging
* Adjacent organ involved; nodes negative — B3
Adjacent organ involved; nodes positive — C3

Of the 62 patients receiving postoperative radiotherapy, seven experienced small bowel obstructions requiring surgical intervention. In two other patients, radiation enteritis developed. These problems were primarily encountered in patients treated with large fields extending superiorly to the L2-L4 level. Complications were less frequent in patients receiving radiation therapy to more limited fields.

The sequence of low-dose preoperative radiotherapy (500-1000 rads) and surgery followed by postoperative radiotherapy in patients with pathologic stages

B2 and C lesions has been studied at Massachusetts General Hospital by Gunderson.[21] Of 15 patients treated with this regimen, disease-free survival at 4 years is 72%. These results are significantly better than those published for surgery alone in stages B2 and C. The complications using this technique have been minimal due to the meticulous exclusion of small bowel from the high-dose region of the radiotherapy treatment fields.

Summary

The incidence of local-regional recurrence in patients with adenocarcinoma of the rectum and rectosigmoid treated with surgery alone is unacceptably high. Almost all of these patients will die of their disease, and only half will experience limited palliation with radiotherapy given at the time of recurrence.

Adjuvant radiotherapy has been shown to significantly decrease the incidence of local-regional recurrence in this setting. There is evidence that preoperative radiotherapy improves the chances of survival as well as decreasing the incidence of local-regional recurrence. Therefore, patients with adenocarcinomas of the rectum or rectosigmoid should be considered for adjunctive radiotherapy. The question as to which regimen is most appropriate (preoperative, postoperative, or sandwich technique) should depend on the experience and judgment of the attending surgeon and consulting radiation oncologist.

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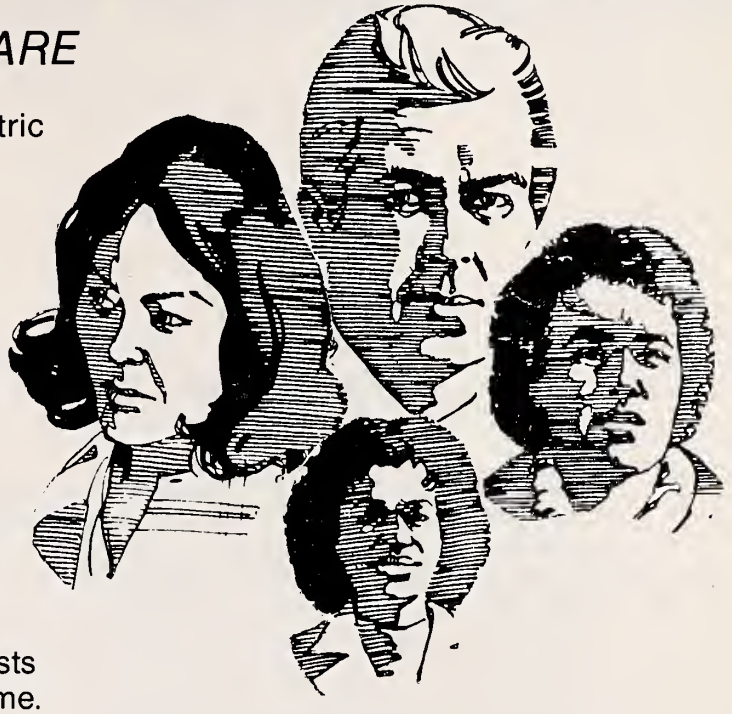
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president's letter



Challenges in the Year Ahead

It is with deep gratitude that I assume this high office as president of the Medical Association of Georgia. When the House of Delegates elected me last year in a real horse race, it was quite a thrill! That three physicians were willing to run was a healthy thing for the Medical Association and I'm sure all three of us were able to get to know more of our delegate colleagues over the state than we could have otherwise.

There are many issues facing us in the coming year that will affect our patients directly and indirectly. The most important one in which we will be involved as MAG members is the cost of medical care. The Medical Association as an organization and the individual physicians who comprise its membership have a duty to help the public become aware of what causes costs to be so high, as well as how the money is being spent. We need to take a leadership role, wherever we are, to do something about it. This starts in the individual office and in the hospitals where we practice. Physicians need to become more involved in the hospitals' efforts to reduce costs as mandated by diagnosis related groups (DRGs).

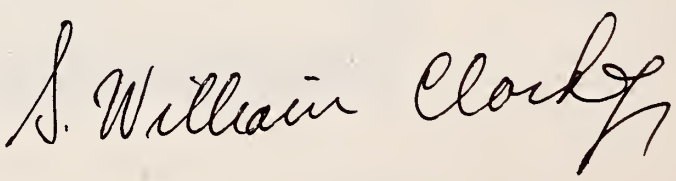
Another major concern of all physicians is that of malpractice costs. Here again, public awareness of the magnitude of this problem is a pressing need. We need also to enlist public support of our efforts to improve some of our tort laws.

Leaders of the MAG will be concerned with other issues as well and will be working to:

1. Reorganize the office staff under a new executive director with the purpose of serving the membership as effectively as possible at the lowest possible cost.
2. Serve as good and responsible stewards of your membership dues dollars.
3. Strengthen the House of Medicine by:
   A. Expanding ties with and services to more specialty societies.
   B. Building a larger physical plant to house not only the MAG headquarters with its component specialty societies but also MAG Mutual Insurance Company and Georgia Medical Care Foundation.
4. Involve more young physicians in the organization. They are our future.
5. Generate involvement of the membership in all levels of the MAG.
6. Broaden our ties with the Auxiliary and utilize them more. Our spouses are our primary backers at home, and their organization has a great potential to help the MAG in all of its endeavors.
7. Improve the liaison between the MAG and other groups involved with health care.

These are formidable and challenging tasks. I will expand on these and other topics on this Page in the coming year.

I look forward with enthusiasm to serving the membership of the Medical Association of Georgia in the coming year.



S. William Clark, Jr., M.D.

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Blake, Gregory H., Muscogee—Service—FP
Martin Army Hospital, Fort Benning 31905

Butler, Elizabeth D., MAA—I&R—IM
Dept. of Medicine, Emory University School of Medicine, Atlanta 30322

Carroll, Cheryl K., Muscogee—ACT (N-2)—NPM
1968 North Ave., Columbus 31995

Derrick, Bob L., MAA—ACT—GS
5669 Peachtree Dunwoody Rd., NE, Ste. 325, Atlanta 30342

Escalera, Gustavo A., Henry—ACT—GS/VS
Henry Professional Bldg., Ste. 9, Hudson Bridge Rd., Stockbridge 30281

Etchason, Gregory J., Peachbelt—ACT (N-2)—IM
P.O. Box 1435, Fort Valley 31030

Hanzlick, Randy L., MAA—ACT—FOP
50 Coca Cola Place, SE, Atlanta 30303

Healey, Kenneth W., Richmond—I&R—OBG
1706 Kings Wood Dr., Augusta 30901

Holzman, Gerald B., Richmond—ACT—OBG
Dept. of OB/GYN
Medical College of Georgia, Augusta 30912

Hutchings, William S., II, Bibb—I&R
784 Spring St., Macon 31201

Katz, David S., Richmond—ACT—GP/OM
3109 Natalie Cir., Augusta 30909

Kavelman, Douglas A., Randolph-Stewart-Terrell—ACT—IM
Cotton St., P.O. Box 687, Lumpkin 31815

Lammers, John D., Richmond—I&R—IM
Dept. of Internal Medicine, Medical College of Georgia, Augusta 30901

Lee, Steven R., MAA—ACT (N-1)—P
3280 Howell Mill Rd., Ste. 336, Atlanta 30327

Leonard, Michael M., Bibb—I&R—FP
777 Hemlock St., Hospital Box 97, Macon 31201

Lynch, Edwin H., Hall—ACT (N-2)—OBG
1100 Vine St., Gainesville 30501

Malik, Anwar K., South Georgia—ACT (N-2)—PD
104 Woodrow Wilson, Valdosta 31601

Marinkovic, Steven, Gwinnett-Forsyth—ACT—P/N
100 E. Clayton St., Lawrenceville 30245

McAlister, Robert E., MAA—ACT—FP/OM
5669 Peachtree Dunwoody Rd., NE, Atlanta 30342

McAllister, Yvonne P., Bibb—I&R—FP
784 Spring St., Macon 31201

Mitchell, C. Craig, Dougherty—ACT (N-2)—IM/CD
417 Third Ave., Albany 31702

Mithani, Kamrudin K., Bibb—I&R
784 Spring St., Macon 31201

Natrajan, P. K., Richmond—ACT—OBG/END
903 15th St., Augusta 30901

Orr, James B., MAA—I&R
652 Park Lane, Decatur 30033

Pakalnis, Vytautas A., Richmond, ACT—OPH
Dept. of Ophthalmology, Medical College of Georgia, Augusta 30912

Pechal, Frank D., Bibb ACT (N-1)—GP
P.O. Box 204, Irwinton 31042

Plank, Irwin E., Gordon—ACT—AN/OBG
Pine Chapel Rd., P.O. Box 619, Resaca 30735

Range, John N., Hall—ACT (N-2)—GP
Rte. 2, Box 8, Oakwood 30566

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Ruppel, James W., Cherokee-Pickens—ACT (N-2)—FP
110 Waleska Rd., Canton 30114

Schuman, Bernard M., Richmond—ACT—IM/GE
Medical College of Georgia, Augusta 30912

Sebas, John A., Lumpkin—ACT (N-2)—FP
Dawson Medical Center, P.O. Box 262, Dawsonville 30534

Weinstein, M. Louis, MAA—ACT—DR
11585 Alpharetta St., Roswell 30076

Zubowicz, Vincent N., MAA—ACT (N-2)—PS
25 Prescott St., NE, Atlanta 30308

PERSONALS

First District

Wesley J. Ball, M.D., of Savannah, attended the 11th annual Surgical Forum sponsored by the University of Mississippi Medical Center in Jackson. The 3-day forum focused on several controversial and difficult surgical problems and was highlighted by lectures and discussions on updated surgical procedures and trauma management.

Two Savannah physicians, **Alton F. Williams, M.D.,** and **Joseph Pacifici, M.D.,** have announced their retirements due to illness. Dr. Williams has been practicing for 50 years. He graduated from Mercer University and the University of Georgia Medical School. Dr. Pacifici graduated from Harvard College and the University of Rome Medical School. In the 1950s, both doctors were instrumental in promoting Savannah's third hospital, Memorial Medical Center. Dr. Williams served as Memorial's 1st Chief of Medicine and Dr. Pacifici was Chairman of the Chatham County Hospital Authority for 6 years.

Fourth District

Ernest C. Fokes, Jr., M.D., of Decatur, was recently recognized by the Social Security Administration for his contribution to the health and well-being of Social Security employees throughout eight southeastern states.

Fifth District

Raymond V. Caputo, M.D., of Atlanta, was elected to Fellowship in the American Academy of Pediatrics.

Pediatrician **James Densler, M.D.,** received an award from Morehouse School of Medicine for his contributions to the development of the educational program of that medical school. He received the award in February at a banquet of the Atlanta Medical Association.

Brit B. Gay, Jr., M.D., Professor of Radiology at the Emory University School of Medicine and Chief of Pediatric Radiology at the Henrietta Egleston Hospital for Children, was named to a 2-year term as president of the Southern Pediatric Radiology Society at the group's annual meeting held at Williamsburg, VA, March 1-4. Dr. Gay is also serving a 3-year term as councilor from Georgia to the American College of Radiology.

John T. Godwin, M.D., of Atlanta, reports that the laboratory of the King Faisal Specialist Hospital and Research Centre, Riyadh, Kingdom of Saudi Arabia, has been inspected and accredited by the College of American Pathologists. This is the highest certification attainable for a medical laboratory. This is the only non-U.S. governmental laboratory in the world to be so accredited outside the United States. Dr. Godwin has been serving as Chairman of the Department of Pathology and Laboratory Medicine at the King Faisal Specialist Hospital and Research Centre for nearly four years.

John Rhodes Haverty, M.D., Dean of the College of Health Sciences at Georgia State University in Atlanta, has been awarded the Aven Cup by the Medical Association of Atlanta. Dr. Haverty's specialty is pediatrics.



Ernest C. Fokes, Jr., M.D., (right) and Gordon M. Sherman, Regional Commissioner, Social Security Administration.

Atlanta general surgeon, **John T. Mauldin, M.D.,** recently received a plaque of appreciation from the Social Security Administration for his outstanding leadership in the administrative and medical activities relating to the disability program.

Sixth District

Pruitt Woodall, M.D., recently retired after almost 50 years of practice in Thomaston. Dr. Woodall graduated from Emory University School of Medicine. He served 3 years of internship at the Macon City Hospital and then served in the 3rd Army 1st Armored Division under Gen. Patton. He specialized in orthopedic surgery for the last 20 years of his practice.

Tenth District

Louis Arrue, M.D., is opening an office in Monroe. He is chairman of the pediatrics departments of Newton General Hospital and Rockdale County Hospital.

General practitioner **Julian Hutchins, M.D.,** moved his practice from Thomson to Commerce on March 1.

DEATHS

George H. Alexander

George H. Alexander, M.D., former president of the Medical Association of Georgia, died March 27, at the age of 83. Dr. Alexander graduated from Emory University School of Medicine. He served as president of the MAG in 1965-66 and was a founder of the Georgia Academy of Family Physicians and its president in 1954-55. In 1968, he was selected as Georgia's Family Doctor of the Year. Dr. Alexander practiced family medicine in Forsyth for 45 years.

Survivors include his wife, one son, one daughter, and two sisters.

Committee Activities . . .

Highlights — March, 1984, MAG Executive Committee Meeting

Maternal & Infant Health (M&I) Task Force — The Chairman outlined the Task Force's decision to develop and implement an awareness campaign emphasizing infant mortality in the State of Georgia. The campaign will include letters to local county medical societies with local data sheets containing information; letters to obstetricians, pediatricians, family physicians, and other appropriate people encouraging them to participate in provisions of the required medical care and keeping them informed of changes in the Medicaid scam; a referral system involving local medical societies, hospital medical staffs, health departments, etc.; a counseling program using teenagers' points of view in discussions regarding pregnancies; and MAG Auxiliary participation in encouraging physicians to become involved in these efforts. The Chairman also expressed the desires of the MAG PR Committee and the DHR Department of Public Health to work together on implementing these suggestions and activities. The Executive Committee approved the suggestions of the Task Force and encouraged them to proceed with these activities.

Public Relations Committee — Several ideas being implemented by the PR Department were presented:

(1) A brochure on "Selecting a Physician."
(2) A Joint MAG/DHR Child Abuse Campaign using public service announcements on TV/Radio, slide/tape shows.
(3) Operation Care.
(4) Billboard campaign to educate the public on the law referred to as the "Child Restraint Law" that becomes effective on July 1, 1984.
(5) Assistance to the M & I Task Force on a public awareness program regarding indigent care and teenage pregnancies.
(6) A slide show entitled "MAG: What's In It For You?" which will be presented to the MAG House of Delegates in April.
(7) A PR Manual for county medical societies to be used for conducting local campaigns.
(8) Letters to committee chairmen and county medical society secretaries and staff to ascertain how the PR Department can assist in any campaign which they might wish to conduct.

The Executive Committee directed the PR Committee to proceed with their activities and accepted their report as information.

Third Party Relations — The Chairman requested direction pertaining to the Department of Medical Assistance's request that MAG assist in developing a Mandatory Second Surgical Opinion Program. Following discussion, the Executive Committee voted to change part of MAG's September, 1978, position statement on Second Opinions to read: "The conditions of participation outlined in the programs have varied somewhat but for the most part, these conditions seem to be in opposition to the traditional concepts of medical consultation." In another action, the Executive Committee approved Dr. Moore's responding to the Commissioner of the DMA, reaffirming this policy and including the AMA policy on Second Opinions.

Committee on Legislation — Informed Consent, Breast Cancer: It was reported that this legislation only required a booklet to be authored and distributed by the Composite State Board of Medical Examiners to physicians and their patients. The Executive Committee requested the MAG Cancer Committee to assist in the preparation of this booklet on breast cancer.

DHR Grant Support — The Georgia Department of Human Resources in collaboration with Emory University School of Medicine, authored a grant proposing to establish a Statewide Health Promotion Program to coordinate and maximize the utilization of available resources targeted to major risk factor areas, i.e. — smoking, obesity, nutrition, sedentary lifestyles, stress reduction, and environmental safety. The Executive Committee voted to send a letter of support for this grant request to DHR.

Nuclear Magnetic Task Force — Dr. Moore reported on correspondence with the State Health Planning Agency about its NMR Task Force recommendations that there be only two units in Georgia, one each at the Medical College of Georgia and the Emory University School of Medicine. He emphasized that because these units have the potential of becoming a major improvement in body imaging, the demand will rapidly increase and the cost will decrease, at which time these two units will not meet the needs of the five million people in Georgia.

Appointments to Computer Education Committee — On motion, the Executive Committee appointed the following physicians to the newly formed MAG Committee on Computer Education:

Edward D. Biggerstaff, III, Savannah
Floyd P. Garrett, Atlanta
William H. Headley, Milledgeville
Richard C. Mattison, Atlanta
Jack F. Menendez, Macon
William M. McClatchey, Atlanta
James H. Sullivan, Columbus

Appointments to Medical Board of Workers' Compensation — The Executive Committee approved the following list of physicians from MAG to be submitted to Governor Harris for appointment to the Medical Board of the Workers' Compensation Board:

Pathology: L. Davis Stacey, Atlanta
Gerard Verly, Atlanta
Chest Disease: Walter S. Dunbar, Atlanta
Frank J. Cook, Atlanta
Radiology: Richard A. Elmer, Atlanta
Albert A. Rayle, Atlanta
Dermatology: Robert Reitschel, Norcross
Beverly B. Sanders, Jr., Macon



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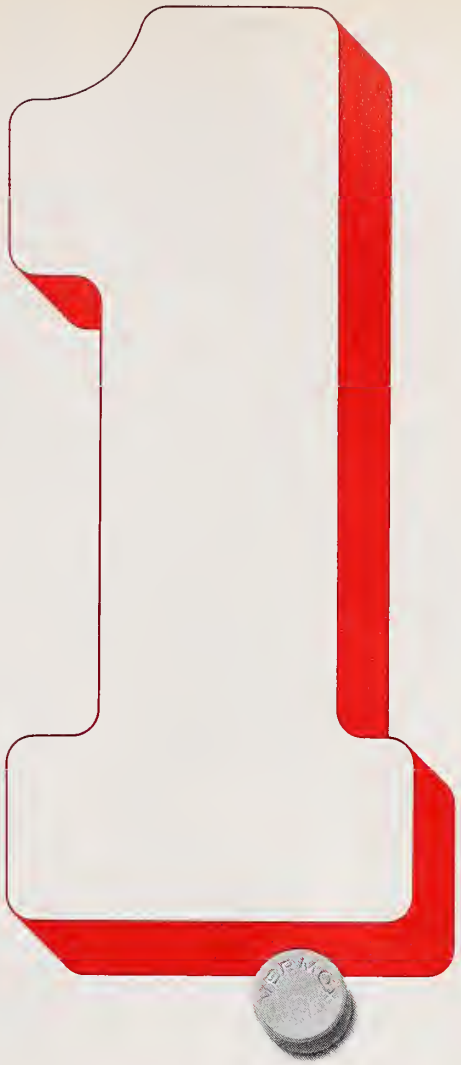
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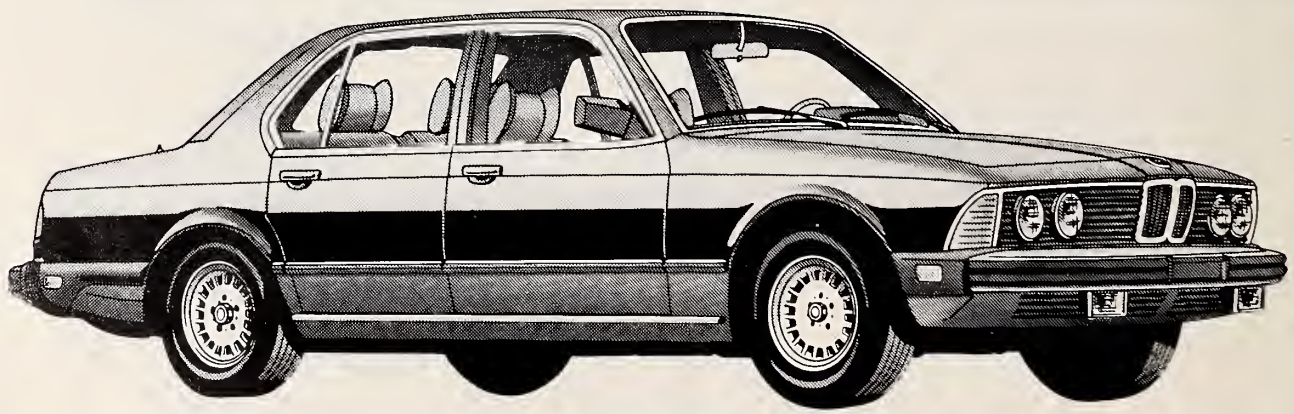
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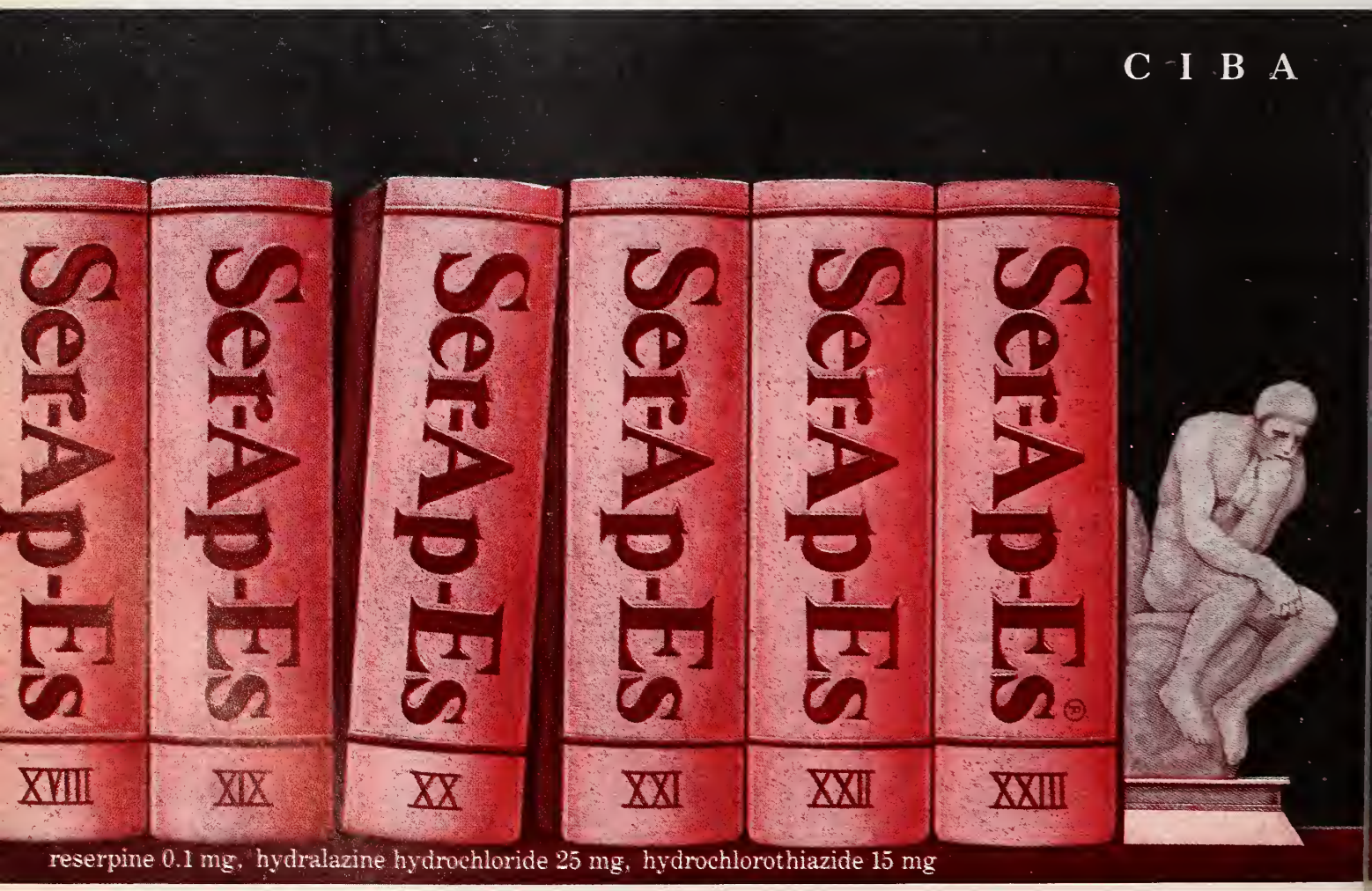
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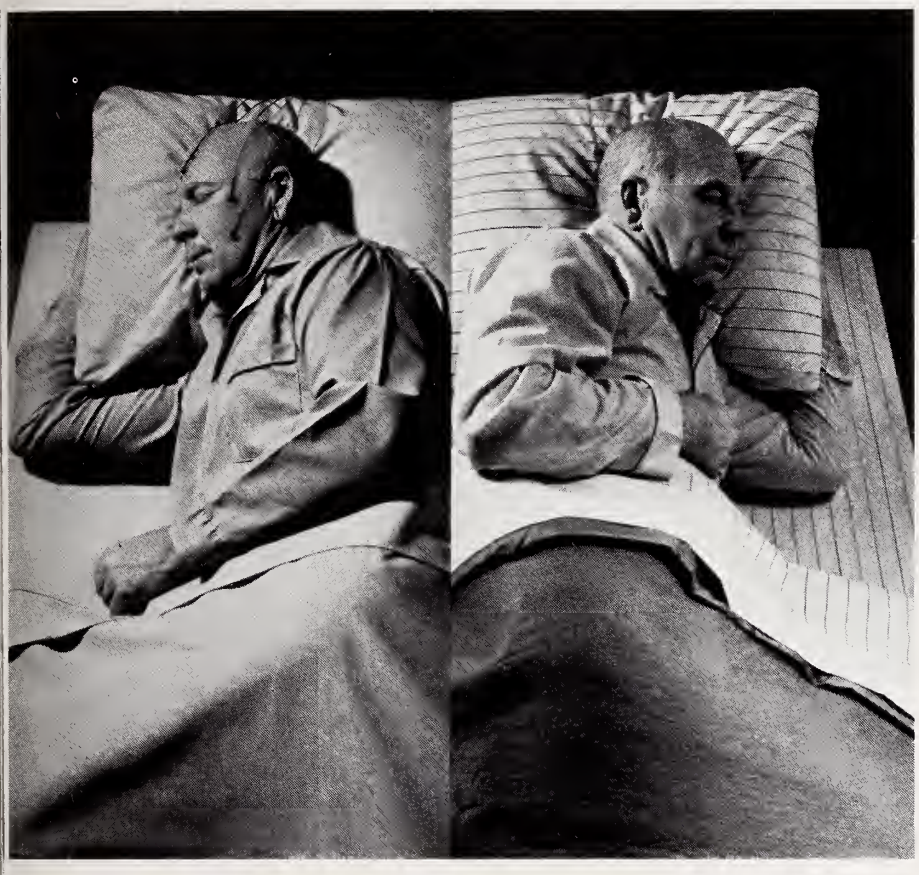
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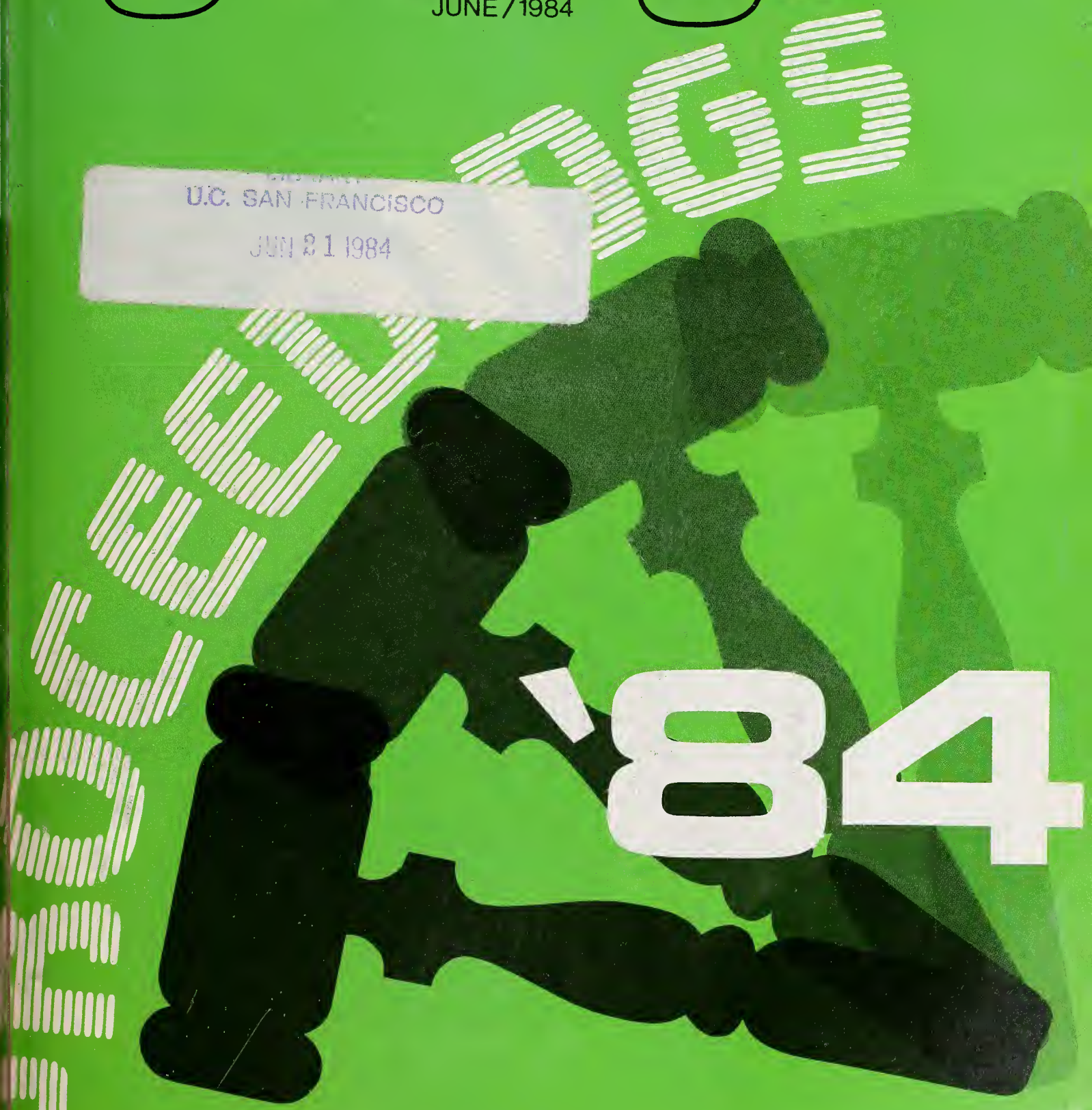


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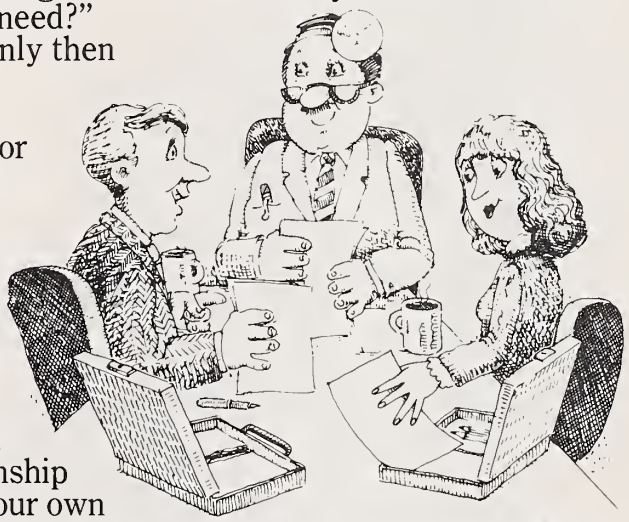
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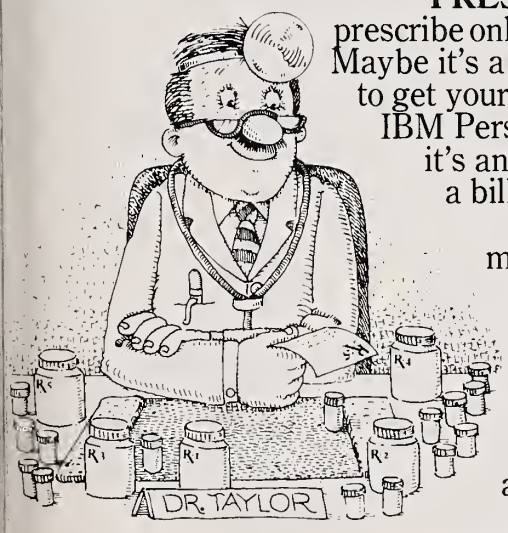
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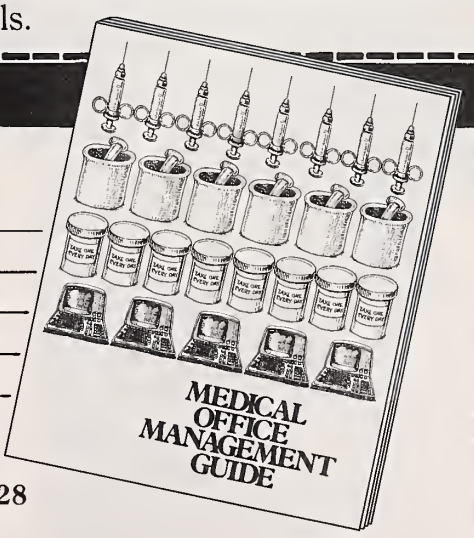
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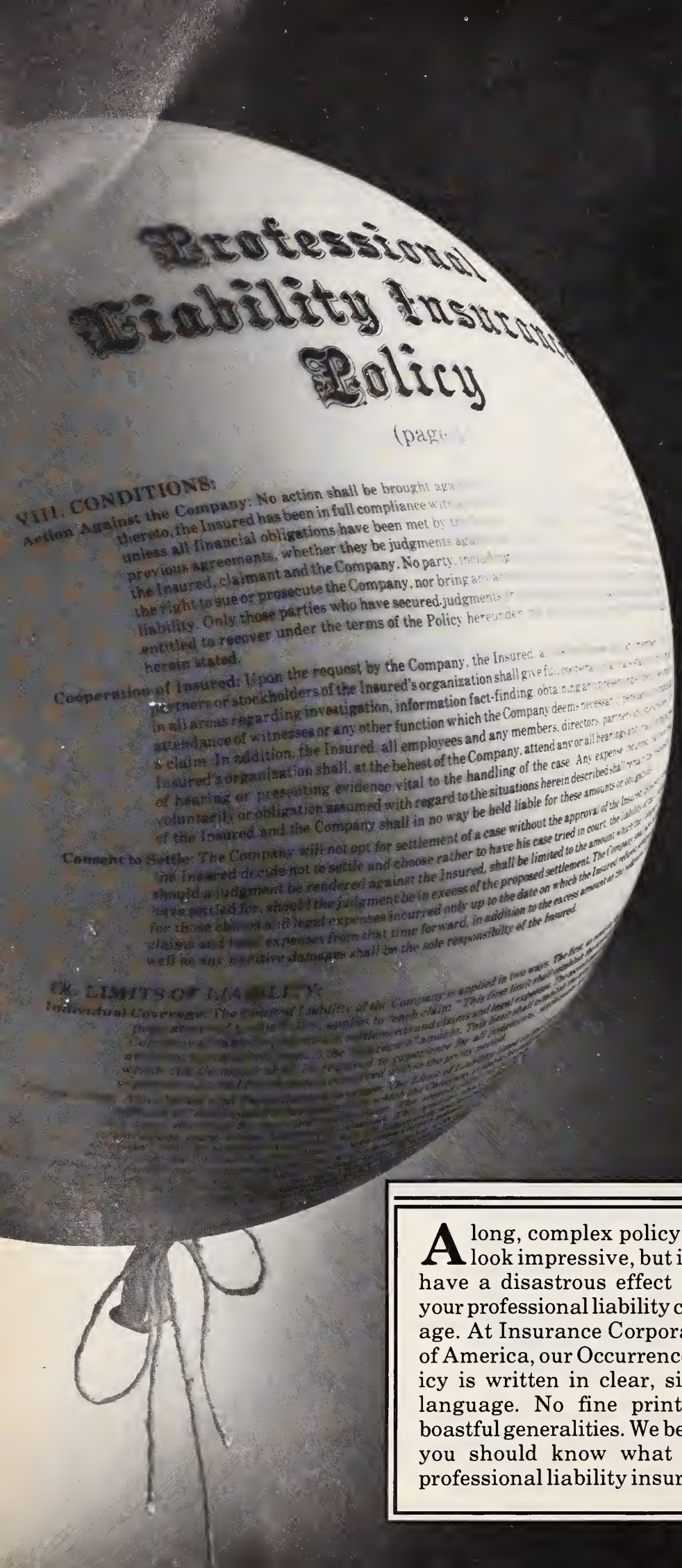
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Established 1911. Owned and edited by the Medical Association of Georgia. Published monthly under the direction of the Board of Directors of the Association. Printed by The Ovid Bell Press, Inc., Fulton, Missouri.

Copyright, 1984, Medical Association of Georgia. The *Journal*, its editors, and the Medical Association of Georgia are not responsible for the opinions and statements of its contributors and advertisers.

The subscription price per year for members of the Medical Association of Georgia is $7.50, included in the annual membership dues. The subscription price for nonmembers is $15.00 in the United States, Canada and Mexico, and $17.00 in other countries. Single copies are $2.

The *Journal of the Medical Association of Georgia* is published monthly at 938 Peachtree Street, N. E., Atlanta, GA 30309-3990. Second-class postage paid at Atlanta, Georgia, and at additional mailing offices. POSTMASTER: Send address changes to Medical Association of Georgia, 938 Peachtree Street, N. E., Atlanta, GA 30309-3990.

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president's letter



Health Care Costs and You

THE ENTIRE ISSUE of the cost of medical care is so frustrating and complex that one's initial reaction is to ignore it. We as physicians no longer have that luxury. There are actions by business and government which demand that we become informed and involved. Physicians' indifference to what is going on while saying, "I have to spend all my time treating sick people," will no longer suffice.

Physicians have a duty to become informed themselves and point out to the public some of the reasons for the current high cost of medical care. These include:

1. Demand by the public for the best medical care available regardless of cost. Yet many people harbor the fallacious notion that medical care provided by insurance contracts and government programs "doesn't cost anyone anything."

2. Government insistence that it is the right of all Americans to receive the best quality medical care available in the world, regardless of cost or the patient's ability to pay. To undergird this notion, the government has spent untold millions of the taxpayers' dollars for such programs as medical school capitation and research grants, Medicare, Medicaid, and the National Health Service Corps, etc.

3. General inflation.

A. Labor costs, which have risen at a higher rate than other facets of inflation and which account for the majority of total hospital costs.

B. Increased food and utility costs.

C. Malpractice insurance premiums, which have risen astronomically.

4. First day, first dollar comprehensive health insurance provided by industry to employees as a result of labor-management negotiated contracts.

5. Reimbursement to hospitals by the Medicare program on a cost basis, a policy which essentially has provided a blank check to hospitals and has not required the minimum effort to run an efficient or cost effective operation.

What has happened? The government is now more concerned with cost than with quality of care and in a classic example of overkill, has established the DRG (Diagnosis Related Groups) Program. Business and industry are forming health-care coalitions for the express purpose of reducing costs.

Although physicians' fees account for less than 20% of the health care dollar, we are the most visible, so we are widely considered to be the culprits in this whole affair. This is clearly not so, but it still behooves us to become involved in any effort to control the rise in costs of medical care.

In our daily practice, we need constantly to be aware of the costs of medical care and do what we can, individually, to render the best quality care possible at the lowest cost. We should never compromise quality.

Our patients deserve the best. It is up to us to assure that they will continue to be able to afford it.

S. William Clark

S. William Clark, Jr., M.D.

MEDICAL MEETING CALENDAR

JUNE

21-23—*Hilton Head, SC:* **Neurology.** AMA Category 1 and AAFP prescribed credits. Contact Div. of Cont. Ed., MCG, Augusta 30912. PH:404/828-3967.

21-23— *Sea Island:* **Georgia Chapter, American Academy of Pediatrics Spring Meeting.** Category 1 credit. Contact William C. Mankin, Exec. Secy., Ga. Chapter, Amer. Acad. of Ped., 4059 Land O'Lakes Dr., N.E., Atlanta 30342. PH:404/327-3922.

JULY

12-14—*Kiawah Island, SC:* **Obstetrics.** AMA Category 1 and AAFP prescribed credit. Contact Div. of Cont. Ed., MCG, Augusta 30912. PH:404/828-3967.

13-15—*Sea Island:* **Providing Quality Medical Care in Your Practice.** Contact Southern Med. Assn., 2601 N. Highland Ave., Box 2446, Birmingham, AL.

23-25—*Kiawah Island, SC:* **Pediatric Update — 1984.** AMA Category 1 and AAFP prescribed credit. Contact Div. of Cont. Ed., MCG, Augusta 30912. PH:404/828-3967.

26-28—*Kiawah Island, SC:* **Clinical Genetics.** AMA Category 1 and AAFP prescribed credit. Contact Div. of Cont. Ed., MCG, Augusta 30912. PH: 404/828-3967.

AUGUST

2-5—*Kiawah Island, SC:* **Critical Care Medicine.** AMA Category 1 and AAFP prescribed credit. Contact Div. of Cont. Ed., MCG, Augusta 30912. PH:404/828-3967.

6-10—*Hilton Head, SC:* **Your Practice, Your Money, Your Family.** Category 1 credit. Contact Div. of Cont. Ed., MCG, Augusta 30912. PH:404/828-3967.

11—*Atlanta:* **Experimental Hematology.** Category 1 credit. Contact Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., NE, Atlanta 30322. PH:404/329-5695.

12-16—*Amelia Island, FL:* **Abdominal and Neuroimaging — Interventional Techniques.** Category 1 credit. Contact Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., NE, Atlanta 30322. PH:404/329-5695.

13—*Atlanta:* **Comprehensive Board Review in Internal Medicine.** Category 1 credit. Contact Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., NE, Atlanta 30322. PH:404/329-5695.

14-16—*Atlanta:* **Let's Talk Family Planning.** Category 1 credit. Contact Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., NE, Atlanta 30322. PH:404/329-5695.

17-19—*Jekyll Island:* **Georgia Psychiatric Association Summer Meeting.** Category 1 credit. Contact J. Tom Sawyer, MAG, 938 Peachtree St., N.E., Atlanta 30309. PH:404/876-7535 or 1-800-282-0224 (toll free in Ga.).

SEPTEMBER

6-8—*Atlanta:* **Southeastern Occupational Health Conference.** Contact T. R. Hatfield, MD, P.O. Box 71, West Point 31833. PH:404/756-7111, ext. 2204.

12-14—*Savannah:* **Neonatology — The Sick Newborn.** Category 1 credit. Contact Div. of Cont. Ed., MCG, Augusta 30912. PH:404/828-3967.

14-16—*Hilton Head:* **The Georgia Society of Anesthesiologists and the South Carolina Society of Anesthesiologists Fall Meeting.** Category 1 credit. Contact William Hammonds, Secy.-Treas., Ga. Society of Anesth., Emory Univ. Hosp., 1364 Clifton Rd., NE, Atlanta 30322. PH:404/321-0111.

20-23—*Sea Island:* **Georgia Surgical Society Annual Meeting.** Category 1 credit. Contact William McGarity, M.D., Emory Univ. Clinic, 1365 Clifton Rd., NE, Atlanta 30322. PH:404/321-0111, ext. 3322.

21-22—*Atlanta:* **Office Urodynamics.** Contact Merrily Laube, Southern Found. for Edu. and Medical Research, Inc., 98 Currier St., Atlanta 30308. PH:404/688-3323.

28-30—*St. Simons Island:* **Georgia Gastroenterologic Society Annual Scientific Sessions.** Category 1 credit. Contact Theodore Hersh, M.D., Emory Clinic, 1365 Clifton Rd., NE, Atlanta 30322. PH:404/321-0111.

OCTOBER

4-6—*Atlanta:* **Endourology.** Contact Merrily Laube, Southern Found. for Edu. and Medical Research, Inc., 98 Currier St., Atlanta 30308. PH:404/688-3323.

4-6—*Hilton Head, SC:* **Frontiers in Nutrition** (cosponsored with Vanderbilt Univ. Sch. of Med.) AMA Category 1 and AAFP prescribed credit. Contact Div. of Cont. Ed., MCG, Augusta 30912. PH:404/828-3967.

18-21—*Sea Island:* **Georgia Orthopaedic Society Annual Meeting.** Category 1 credit. Contact William Collins, M.D., Secy.-Treas., GOS, 993 Johnson Ferry Rd., NE, Ste. 100, Atlanta 30342. PH:404/255-4582.

23-27—*Atlanta:* **27th Annual Radiology Conference: NMR.** Category 1 credit. Contact Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., NE, Atlanta 30322. PH:404/329-5695.

NOVEMBER

5-10—*Atlanta:* **American Society of Cytology.** Contact ASC, 130 S. 9th St., Ste. 810, Philadelphia, PA 19107. PH:215/922-3880.

11-16—*Atlanta:* **American Academy of Ophthalmology.** Contact AAO, P.O. Box 7424, 1833 Filmore St., San Francisco, CA 94120. PH:415/921-4700.

15-18—*Atlanta:* **Georgia Academy of Family Physicians' Annual Meeting.** Category 1 and AAFP prescribed credit. Contact Camille Day, Exec. Vice-Pres., GAFP, 11 Corporate Square, Ste. 205, Atlanta 30329. PH:404/321-7445.

16-18—*Atlanta:* **MAG Scientific Assembly.** Category 1 credit. Contact Stephen Davis, Dir. of Ed., MAG, 938 Peachtree St., N.E., Atlanta 30309. PH:404/876-7535 or 1-800-282-0224 (toll free in Ga.).

editorial
editorial
editorial

Speaker's Eye View of the Annual Session



THE ANNUAL SESSION of the Medical Association of Georgia is held in April, and from the standpoint of MAG activities, it begins the work year. About 180 delegates come to the meeting, starting on Thursday evening. The meeting continues through Saturday afternoon.

I was asked to write a paper giving the Speaker's eye view of the Medical Association's Annual Session. As background for those of you who are not delegates, I feel that an overview of the Medical Association's year, from the Speaker's perspective, would be worthwhile.

The Building of a House

The preparation for the 1984 Annual Session started in May, 1983, just after the 1983 Annual Session. The Speaker, Vice Speaker, and MAG staff who serve on Reference Committees critiqued the Session in an attempt to find out what went wrong and what could be improved upon. These evaluations included the facility: were the meeting rooms and housing adequate and pleasing to the delegates? The opinion of the staff concerning various Reference Committee reports was sought: how could the reports have been written more clearly, thereby obviating much controversy? How did the various physicians on Reference Committees function? Who among them is interested in acting as Chairman or Vice Chairman? By evaluating these factors as well as many others, we attempt to find good facilities in which to have the Annual Session and interested capable physicians to serve on the Reference Committees. We also try to improve the procedure as much as possible.

Following this evaluation, attention is turned to the implementation of policy set forth by the delegates at the Annual Session. But it is in January that planning for the upcoming Annual Session starts in earnest. The Speaker and MAG staff go to the hotel (or other facility) where the Annual Session will be held. The needs of the Association are discussed with hotel staff in an attempt to evaluate the traffic patterns for the Reference Committees and House of Delegates meetings rooms, as well as the setup for these rooms, the audiovisual facilities, the restaurant facilities, etc. It usually takes me 2-3 visits to completely evaluate and understand the facility.

At the beginning of the year, letters are sent to the county medical societies around the state asking them to submit names of the society members who are interested in serving on Reference Committees. From these lists, the Reference Committees are selected with an attempt to balance the committees with both experienced people and inexperienced people who are interested in learning about

the Reference Committee system. In this way, we always have enough people to serve effectively on the Reference Committee. From this time until the Annual Session, there are almost weekly meetings held between the Speaker, Vice Speaker, and Mr. Tom Sawyer, the staff member directly responsible for the Annual Session. In addition to these meetings, there are multiple phone calls as we try to go over committee assignments, staff assignments, etc.

The Delegates Handbook is being prepared at this time, as committee reports, officer reports, and resolutions are received. It is distributed to the delegates as quickly as possible, usually in the first week of April. By this time, a considerable amount of preparation for the Annual Session has been done.

The Annual Session starts on Thursday evening with a General Session, chaired by the President of the Association, at which time awards are given out, achievements are noted, and other activities occur. The First Session of the House of Delegates begins after this. At this time, the Speaker gives instructions to the delegates concerning the order of business and the various committees' assignments, and nominations are made for election of officers for the Association and the AMA Delegation. On Friday morning, the Reference Committees meet. They then write reports Friday afternoon. The delegates meet for their Second Session to consider these reports on Saturday. With this background, I would now like to give you the "Speaker's Eye View" of the April, 1984, Annual Session.

The Speaker's Odyssey

For me, the Session starts with the Wednesday afternoon Executive Committee meeting. I leave Macon, approximately 30 minutes late, hoping to make up part of the time on the road, only to run into a monumental traffic jam on the Southeast Expressway in Atlanta. I arrive almost an hour late. The Executive Committee meeting and the Board of Directors meeting the next day are shorter than normal because many of the items that the Executive Committee ordinarily discuss, such as budgetary matters, will be discussed in full at the Annual Session. The Board of Directors meeting is all day Thursday. The Board reviews the reports and resolutions to come before the House of Delegates, takes a position, if it so desires, on these matters, and relays this information to the House.

Thursday evening at 8:00, the first General Session begins and is presided over by Dr. Bill Moore, our president. As he is walking to the podium, a member of the staff comes up to say something to him, and he says "don't worry, I'm not going to ask the dead folks to stand up," a remark that I find extremely funny. I have difficulty keeping a straight face when he does call the roll of our members that died the preceding year. Dr. Moore is very witty, with a dry sense of humor, and sometimes it's only a few minutes after he has said something that I appreciate the wit in his remark. My mirth soon turns to dismay, however, as I realize that we are going way over the projected starting time of 8:00 for the House of Delegates session, but I personally feel that the General Session is very well done and worth the time spent.

At 9:00, one hour later than I am supposed to start, I call the First Session of the House of Delegates to order and attempt to cut down on the time. We (the Vice Speaker and I) decide to do away with nominating speeches for the sixteen unopposed candidates in an attempt to keep the Session from going on into the late evening. By streamlining the Session as much as possible, we get through at about 9:30 PM, having given full time to the contested office of treasurer and cut short significantly the time alloted to the uncontested offices. We also elect all uncontested officers, for both the MAG and AMA at this time. I feel a sense of relief at getting through at a reasonable time and get all sorts of congratulatory pats on the back from people who I believe had dinner reservations pending.

The next morning at 7:00, the Speaker, Vice Speaker, MAG staff, and Reference Committee Chairmen and Vice Chairmen meet to go over the various Reference Committee functions. The Reference Committee chairmen are briefed on holding the hearings and writing the reports and are given the materials needed for them to

do so. This meeting goes smoothly as usual, and we are through in 15-20 minutes in time to go to the GaMPAC breakfast at 7:30. As I arrive late for the breakfast, Dr. Beverly Sanders walks up and asks my wife and me to sit at the head table. We agree, but I should be suspicious, because we are no sooner seated when he asks me to say the blessing. This has happened to me before, and I usually carry one around with me in my wallet, but I don't have one on this occasion, so I have to make one up. A delegate tells me afterwards that I said something inappropriate in the blessing.

Our speaker for the GaMPAC breakfast is Lieutenant Governor Zell Miller. He gives an absolutely remarkable, humorous speech, discussing the letters that he receives and various comments he has made over the years which might be called "bloopers."

Following the GaMPAC breakfast, the Reference Committees get down to work and start their hearings. The first problems start to arise, notably that the Reference Committees have completed part of their business and are waiting for the submitter of several resolutions to come and clarify the meaning of some of his resolutions. (This person submitted 8-9 resolutions.) I am then told that this person is not in town. One Reference Committee chairman contacts him by phone and has him explain one of his resolutions. When I realize that he is not going to be able to discuss his resolutions, I then instruct the Reference Committee chairmen to do the best they can to arrive at an action on the resolutions before them. I estimate that this is going to throw us some 2-3 hours late in completing our business.

By approximately 1:30-2:00 PM all of the Reference Committees are through hearing testimony and have gone into executive session to write their reports. I circulate among the Reference Committees to determine if they need to hear from any particular person or legal counsel. I find that over the years, legal counsel is called in more and more as we deal with problems that might involve the FTC and other regulatory bodies. Both Dick Vincent and Bob Berg are on hand, and they go into several of the Reference Committee and executive committee sessions and advise on their decisions.

By mid to late afternoon, we are in the report-typing stage. The Reference Committee chairmen, MAG staff, Vice Speaker, myself, and legal counsel all congregate in the MAG workroom where MAG secretaries, the famous "Traveling Typing Pool" are working hard to type copy from the hand written reports submitted to them. As the reports come off the typewriters, page by page, the staff and the Reference Committee chairmen review them very carefully and make any corrections. It is here that I enjoy watching the action of the various Reference Committee chairmen and seeing their personalities emerge. To show you the dedication of these men, one of the Reference Committee chairmen was ill a few weeks prior to the Annual Session, but he insisted on serving as chairman and did an excellent job. (I had hedged my bet and appointed as a backup another capable delegate who had experience as a Reference Committee chairman. He received the full briefing in case he had to step in the other man's place.)

Dr. Mac Molnar, chairman of Reference Committee A, carefully went over every word and punctuation mark of his Reference Committee report with his staff member and then gave it to me. I know from experience that when Mac hands me his initialed report, it will be clear, concise, and correct, even to the punctuation. All I have to do is initial it. I read the report, and it is as good as I expect: Mac is almost daring me to find anything wrong with it. I don't, and it is ready for the printers. The same thing is true of the report of Reference Committee B, chaired by Dr. Richard Cohen, and in very short order that report is also ready for the printers; likewise Reference Committee F, chaired by Dr. Cyler Garner. Our three new Reference Committee chairmen also submit surprisingly good reports; they are Drs. Rick DuBois for Constitution and Bylaws, Bob Logan for Reference Committee C, and Bill Hardcastle for Reference Committee D. These reports require a little more assistance to achieve the proper format, but all in all the reports are well written and ready to go to the printers by midnight. The reports are then

printed in sufficient numbers to give to all the delegates so they can go to the breakfast caucuses and review them prior to the House of Delegates meeting at 9:00 AM Saturday. I then go up to my room and review my parliamentary procedure table, as well as the reports and resolutions.

Saturday morning, I am up early to get to the breakfast caucus of my delegation, and go quickly down to the meeting hall only to find that they are very slow in setting up and not approaching ready as we are getting ready to start the session at 9:00. Tom Sawyer and I work together, finally get the head table, microphones, and lecterns set up just minutes before the 9:00 starting time. As usual, the delegates come in slowly, and I try to hurry them along. It is approximately 9:12 when we start the session. Dr. Joseph Boyle, president of the AMA, is our speaker. I find Dr. Boyle's remarks very interesting and pertinent, but in all honesty, I am "antsy" to get the Session started.

Shortly after 10:00 AM, we start the first Reference Committee report, Reference Committee on Constitution and Bylaws, chaired by Dr. Rick DuBois. He has done an excellent job in writing the report, the preparation is there, and the report goes well with minimal unforeseen problems. Following this is Reference Committee B's report, given by Dr. Richard Cohen. Again I observe that the report goes very well.

The election for the only contested officer, the 3-year term of Treasurer, is held during the morning session and is won by Dr. Cyler Garner of Gordon in a close vote, 89-85, over Dr. Charles Underwood, of Marietta.

Then the third report of the morning is Dr. Cyler Garner's Reference Committee F; the budget is adopted, as well as a $75 dues increase. Dr. James Sullivan, our outgoing Treasurer, had been concerned that the dues increase might not be accepted, and I had promised him he could have the floor if the increase were rejected. It is about 12:15 PM at this point, and I offer the delegates the choice of breaking for lunch or working on Reference Committee A's report. The delegates opt for lunch. After lunch, we have Reference Committee A's report, followed by Reference Committees C and D, chaired respectively by Drs. Bob Logan and Bill Hardcastle. These reports also go very well. All in all, the day goes well, and the final report ends at 4:40 PM.

The last General Session of the House begins immediately when Dr. Bill Moore passes the gavel over to Dr. Bill Clark who then adjourns the General Session. Following this is the organization meeting of the Board, at which time Dr. Joe Nettles is re-elected as Chairman, and Dr. Bill Collins, in absentia, is re-elected Vice Chairman. By this time, I am totally drained; a combination of exhilaration and fatigue have settled over me. I sit down for approximately 30 minutes and write my notes on the various reports of the Reference Committees, noting the errors that were made in their writing, so that hopefully I can refine these reports for next time.

So there you have the "speaker's eye view of the Annual Session," the eye is sanguine (both meanings — bloodshot and hopeful). I always have the feeling there is not quite enough time to do all of the things that need to be done as well as they need to be done. I can only hope that I will do a better job next year.

In case this article sounds like I do all the work myself, let me hasten to add an emphatic no. I want to acknowledge all the hard work done by MAG staff, especially Tom Sawyer and the secretaries who typed the reports under difficult conditions; Dick Vincent and Bob Berg, our legal counsel; the Reference Committees, especially the chairmen; and Dr. Jim Kaufmann, the Vice Speaker.

Jack F. Menendez, M.D., Macon
Speaker of the House

JOURNAL
of the medical association of
georgia

Summary of the Proceedings of the Medical Association of Georgia's 130th Annual Session

April 26-28, 1984, Atlanta, Georgia

First General Session



William W. Moore, Jr., M.D., 1983-84 MAG President, calls the 130th Annual Session to order.

Call to Order

The First General Session of the 130th Annual Session of the Medical Association of Georgia was called to order by the President, William W. Moore, Jr., MD, of Atlanta, at 7:00 PM in Salons 1 and 2 of the Ritz-Carlton Hotel, Buckhead. Dr. Moore introduced Reverend Eric White, Associate Pastor of the Winter's Chapel United Methodist Church, who delivered the invocation. S. William Clark, Jr., MD, President-Elect, led the audience in the Pledge of Allegiance. Jeffrey Nugent, MD, President of the Medical Association of Georgia, the host for this year's Annual Session, extended a hearty welcome to all those present.

Memorial Service

The audience stood in respect as Dr. Moore read the names of those members who had died since the 1983 Annual Session. Included were: Sidky Aboul-Khair, Waynesboro; E. B. Agnor, Atlanta; Stanley P. Aldridge, Decatur; Georgia H. Alexander, Past President, Forsyth; Arthur N. Berry, Fort Meyers, Florida; Mercer C. Blanchard, Columbus; Mark Brown, Augusta; Elisha J. Cain, Columbus; Louis A. Cibelli, Atlanta; Vincent J. Cirincioni, Savannah; Hervey M. Cleckley, Augusta; Murphy K. Cureton, Lafayette; Richard A. Dodelin, Columbus; R. G. Dunn, Donalsonville; Loree Florence, Athens; A. N. Galin, St. Simons Island; P. C. Graffagnino, Hamilton; J. Fletcher Hanson, Macon; H. P. Harrell, North Augusta, South Carolina; Herbert A. Hudgins, Decatur; William A. Kelley, Atlanta; J. Morgan Kellum, Thomaston; James T. Lowe, Macon; Edgar J. Maxwell, Thomson; Harold P. McDonald, Atlanta; Lawrence P. McDonald, Marietta; Voris F. McFall, Fort Valley; Charles H. Mitchell, Augusta; Ronald Redfield, Hartwell; R. M. Reifler, Macon; W. P. Rhyne, Albany; Harry W. Ridley, Sea Island; Emanuel F. Rosen, Savannah; Thomas F. Sellers, Sr., Atlanta; Wyman P. Sloan, Atlanta; William A. Smith, Atlanta; R. P. Thomas, Augusta; John Warkentin, Atlanta; W. Phil Warner, Atlanta; W. Steve Worthy, Carrollton; and Otis W. Yeager, Valdosta.

Certificates of Appreciation

Certificates of Appreciation were awarded to the following people: Mrs. John G. Bates, Cuthbert, as President of the Auxiliary to the American Medical Association, 1983-84; Ronald F. Galloway, MD, Augusta, for serving as MAG Director, Richmond County Medical Society, 1970-84; Vivian C. Gay, RN, Atlanta, for serving as a Volunteer for the Operation Care Program, 1983; Mrs. George R. Jones, Atlanta, for serving as President of the Auxiliary to the Medical Association of Georgia, 1983-84; Ms. Patricia C. Leet, Atlanta, for serving as Director of SHPDA, 1977-84; William D. Logan, Jr., MD, Atlanta, for serving as MAG Secretary, 1978-84; Mr. James M. Moffett, Stone Mountain, for serving as MAG Executive Director, 1961-84; Victor A. Moore, MD, Augusta, for serving as Chairman of the MAG's Education Committee, 1982-84; William W. Moore, Jr., MD, Atlanta, for serving as President of MAG, 1983-84;

Eloise B. Sherman, MD, Savannah, for serving as MAG's First Vice President, 1983-84; James M. Skinner, MD, Griffin, for serving as MAG Director, Sixth District Medical Society, 1974-83; James H. Sullivan, MD, Columbus, for serving as MAG's Treasurer, 1977-84; Wilson Weston, III, MD, Augusta, for serving as Chairman of the MAG's Medicine and Human Values Committee, 1982-84.

Posthumous certificates of appreciation will be presented to the families of Stanley P. Aldridge, MD, Decatur; and Hoke Wammock, MD, LaGrange. Both were longtime active supporters of organized medicine in general and MAG in particular.

Fifty-Year Members

The following physicians were honored for having practiced medicine for fifty years or more: Charles R. Andrews, Jr., Canton; John A. Bell, Jr., Dublin; Braswell E. Collins, Macon; William R. Crowe, Atlanta; J. Harris Dew, Atlanta; F. G. Eldridge, Valdosta; David B. Fillingim, Savannah; Anthony H. Gallis, Athens; Charles S. Glisson, Jr., Atlanta; Kenneth D. Grace, LaGrange; Murl M. Hagood, Marietta; Wilbur D. Hall, Calhoun; William G. Hamm, Atlanta; James P. Hanner, Atlanta; Guy C. Hewell, Atlanta; R. E. Leonard, Augusta; Leonard R. Massengale, Augusta; Arnold P. Mulkey, Millen; John E. Porter, Savannah; C. James Roper, Jasper; James L. Sawyer, Waycross; Charles W. Stephenson, Ringgold; Alton F. Williams, Savannah; and Bernard P. Wolff, Atlanta.

Life Members

Dr. Moore announced that the following members had been awarded Life Membership in the Medical Association of Georgia: L. H. Allen, Augusta; John S. Atwater, Atlanta; Bessie Mae Beach, Columbus; Alfred O. Colquitt, Marietta; Lee R. M. Conn, Columbus; Cecil B. Elliott, Rome; Brent Fox, Columbus; Regina Gabler, Atlanta; James T. King, Atlanta; William P. Leonard, Atlanta; Jack H. Levy, Augusta; James D. Manget, Jr., Atlanta; L. R. Massengale, Augusta; Charles S. McCall, Jr., Albany; E. A. Musarra, Marietta; S. Charlotte Neuberg, Macon; R. F. Payne, Augusta; A. P. Phillips, Savannah; L. K. Powers, Savannah; Carlton W. Sargent, Riverdale; Glenn E. Seymour, Albany; J. Benham Stewart, Macon; and John W. Thompson, Walhalla, South Carolina.

Dr. Moore expressed the hope of all those present that more of the fifty-year and life members would attend future MAG Meetings.

AMA-ERF Checks

Each year, the American Medical Association-Education Research Foundation distributes funds collected in large part by the Auxiliary of the AMA and its various organizations. Mrs. Margaret Syribeys, Chairman of the A-MAG AMA-ERF, assisted Dr. Moore in the presentation of money raised in Georgia to our four medical schools, as follows:

Medical College of Georgia $11,202.60
Emory University School of Medicine $16,333.41
School of Medicine of Morehouse College $1,990.06
Mercer University School of Medicine $1,908.41



William C. McGarity, M.D., Atlanta, receives MAG's highest award, the Hardman Cup, here presented by President Bill Moore.



Edgar Woody, M.D., Atlanta, receives MAG's Distinguished Service Award for his 30 years as Editor of the *Journal of the MAG*. Dr. Bill Moore presented the award at the Thursday night General Session meeting.

Report of the Auxiliary

MAG Auxiliary President, Mrs. Judy Jones, introduced Mrs. John G. (Glenda) Bates, Cuthbert, Georgia, current President of the Auxiliary of the American Medical Association. Mrs. Bates outlined some of the activities of the Auxiliary at the national level.

In addition to the filed written report, Mrs. Jones gave a slide presentation about services provided by Georgia organizations. She expressed the desire of the Auxiliary of the MAG to become a better public relations vehicle for the Association.

Presentation of Awards

The Hardman Cup, Georgia's most prestigious award, was presented to William C. McGarity, MD, Professor of Surgery at Emory University School of Medicine. Dr. McGarity has been instrumental in the development of the Enterostomal Therapy Program at Emory.

Edgar Woody, MD, received the Distinguished Service Award for his thirty years' work as editor of the *Journal of the Medical Association of Georgia*.

Neither the Hardman Cup nor the Distinguished Service Awards are made annually.



Charles R. Underwood, M.D., Marietta, is presented with MAG's Civic Endeavor Award by Dr. Bill Moore, President of the MAG.



Recipient of the 1984 Family Physician of the Year Award is Dr. G. H. Perrow (right), from Jasper. Dr. David S. Sowell (left), from Hapeville, presented the award. In the background are Drs. James H. Sullivan, Columbus, MAG's Treasurer, and Jack F. Menendez, Macon, Speaker of the House.

The recipient of the Civic Endeavor Award was Charles R. Underwood, MD.

David Sowell, MD, Chairman of the Board of the Georgia Academy of Family Physicians, presented Guerrant H. Perrow, of Jasper, with the Family Physician of the Year Award for 1984.

MAG Slide Presentation

A slide show, "MAG: What's In It for You?," produced by the MAG Public Relations Department, received its first public airing. It will be made available for membership recruitment, county medical society meetings, public meetings, etc.

Adjournment

Following several brief announcements, Dr. Moore adjourned the First General Session at 7:50 PM.

Many Happy Returns.

There are but a few things left in life that can guarantee as many happy returns as consistently as the ones you'll get with U.S. Savings Bonds.

When you buy Bonds through the Payroll Savings Plan, you'll get a lot more from them than you'll ever put towards them. That's because a little is taken out of each paycheck automatically and put towards some terrific guarantees. Like guaranteed interest return. Guaranteed tax benefits. And all backed by the most solid guarantee of all. America.

So, when you're looking to get out more than you put in, take a long look at U.S. Savings Bonds. You'll be happier with the returns. Many times over.

Take stock in America.

UNITED STATES SAVINGS BONDS

When you put part of your savings into U.S. Savings Bonds you're helping to build a brighter future for your country and for yourself.

Which Hospital In Central Georgia Is The Only One With A Neuro Intensive Care Unit?

The Medical Center of Central Georgia. In fact, we were the first hospital in the entire Southeast to have such a unit. Our facility is staffed by a hand-picked group of medical professionals who are specifically trained in this highly specialized field. When you have patients who can benefit from treatment in a neuro intensive care unit, you can send them with confidence to The Medical Center.

The Medical Center
of Central Georgia



Among those attending this year's Annual Session, are delegates from Georgia Medical Society in Savannah: (L to R) Drs. Dan Willoughby, Robert B. Quattlebaum, Jr., Joe L. Nettles, and James Patrick Evans.

First Session — House of Delegates

Thursday, April 26, 1984

The First Session of the MAG House of Delegates was called to order by the Speaker of the House, Jack F. Menendez, MD, of Macon, at 8:15 PM, Thursday, April 26, 1984, in Salons 1 and 2, Ritz-Carlton Hotel, Buckhead, Atlanta, Georgia. James A. Kaufmann, MD, Atlanta, served as Vice-Speaker of the House.

The Speaker called for a report from the Credentials Committee which was given by Milton I. Johnson, Jr., MD. He reported 143 duly elected Delegates representing 42 component medical societies in attendance and accordingly announced a quorum of the House was present.

Attendance

Delegates: David W. Adcock, MD, Vincente Ajoy, MD, Joseph M. Almand, Jr., MD, Patrick L. Anders, MD, Robert H. Anderson, Jr., MD, Thomas J. Anderson, Jr., MD, Manolo Apanay, MD, Harold Asher, MD, Julia Ashley, MD, James L. Askew, MD, James E. Averett, Jr., MD, Joseph P. Bailey, MD, William E. Barfield, Sr., MD, John G. Bates, MD, James F. Beattie, Jr., MD, William H. Biggers,MD, H. Duane Blair, MD, Allen Bleich, MD, William L. Bowen, Jr., MD, Stephen Boyle, MD, Robert G. Bradbury, MD, Rupert H. Bramblett, MD, Spencer S. Brewer, Jr., MD, William P. Brooks, MD, Rodney M. Browne, MD, L. C. Buchanan, MD, Billy Burk, MD, Leon H. Bush, MD, Louis G. Cacchioli, MD, Albert A. Carr, MD, A. B. Chandler, MD, George M. Chastain, MD, Joseph T. Christmas, MD, Alvin H. Clair, MD, S. William Clark, MD, Marvyn D. Cohen, MD, Richard W. Cohen, MD, Chappell A. Collins, Jr., MD, Carl Crawford, MD, John W. Darden, MD, Dave M. Davis, MD, H. G. Davis, Jr., MD, R. Carter Davis, Jr., MD, J. H. Deaton, MD, William C. Holmes, MD, Sammie Dixon, MD, F. William Dowda, MD, Richard E. DuBois, MD, Julian Duttera, MD, James P. Evans, MD, Louis H. Felder, MD, Daniel Feldman, MD, Frank L. Ferrier, MD, Ralph E. Fleck, Jr., MD, Lamar L. Fleming, MD, Henry A. Foster, MD, Milton Frank, III, MD, Whitman Fraser, MD, Edwin Galler, MD, Norman P. Gardner, MD, Cyler D. Garner, MD, Kenneth L. Goldman, MD, Stephen R. Goldman, MD, James S. Goodlet, MD, Cary W. Goodman, MD, Joseph W. Griffin, Jr., MD, H. Hilt Hammett, Jr., MD, William R. Hardcastle, MD, J. Harold Harrison, MD, J. Rhodes Haverty, MD, William McKendree Headley, MD, John P. Heard, MD, Irving D. Hellenga, MD, Kenneth C. Henderson, MD, Hugh O. Hodges, MD, Hamilton E. Holmes, MD, William Huger, Jr.,MD, John B. Hunt, MD, Philip Z. Israel, MD, Joseph M. Jackson, MD, C. E. Johnson, Jr., MD, Milton I. Johnson, Jr., MD, Fleming L. Jolley, MD, Charles L. Jones, MD, William B. Jones, MD, W. Dan Jordan, MD, James A.



Jack F. Menendez, M.D., Macon, Speaker of the House.



James A. Kaufmann, M.D., Atlanta, Vice Speaker of the House.

Kaufmann, MD, Ellis B. Keener, MD, Garland E. Kinard, MD, Luella Klein, MD, C. Peter Lampros, MD, Charles Lanford, MD, Bob G. Lanier, MD, William A. Lardin, MD, J. Moultrie Lee, MD, Robert A. Lipson, MD, J. Robert Logan, MD, William D. Logan, Jr., MD, William H. Lumpkin, MD, Mahmud Majanovic, MD, Donald H. Manning, MD, Joe B. Massey, MD, Richard C. Mattison, MD, Alva Louie Mayes, Jr., MD, Charles W. McDowell, Jr., MD, Virgle W. McEver, Jr., MD, LaMar S. McGinnis, Jr., MD, Ray L. McKinney, MD, Frank W. McKinnon, MD, Jack F. Menendez, MD, Arthur J. Merrill, Jr., MD, Frank F. Middleton, III, MD, Joel F. Mikell, MD, Cecil L. Miller, MD, Edmund M. Molnar, MD, W. W. Moore, Jr., MD, Hugo S. Moreno, MD, A. J. Morris, MD, Gerald B. Muller, MD, A. D. Muse, Jr., MD, Joe L. Nettles, MD, Bruce C.Newsom, MD, John S. Newton, MD, Jeffrey T. Nugent, MD, James L. O'Quinn, MD, Romulo Parungao, MD, Robert M. Patton, MD, Harry Porter, Jr., MD, Stuart H. Prather, Jr., MD, Quentin Price, MD, Dent W. Purcell, MD, Robert B. Quattlebaum, Jr., MD, J. B. Rabun, MD, Jack A. Raines, MD, Harold S. Ramos, MD, William Rawls, MD, Walker L. Ray, MD, John E. Roberts, MD, Michael Roberts, MD, Ronald P. Roper, MD, Arnold J. Rosen, MD, Clyde B. Rountree, MD, Gerald Sanders, MD, Steven L. Sanders, MD, Milton B. Satcher, Jr., MD, Virendra M. Saxena, MD, J. K. Schellack, MD, Tom Schoberg, MD, Eric C. Segerberg, MD, Robert Simmons, MD, Barry D. Siverman, MD, James M. Skinner, MD, Edward H. Smith, Jr., MD, Henry Briggs Smith, MD, James E. Smith, MD, Patton P. Smith, MD, Robert W. Smith, III, MD, Robley D. Smith, MD, Ethan F. Staats, MD, Richard A. Stappenbeck, MD, Robert J. Starling, MD, Dan B. Stephens, MD, Joe C. Stubbs, MD, O. Wytch Stubbs, Jr., MD, James H. Sullivan, MD, Roland S. Summers, MD, Pedro L. Tamayo, MD, Luther M. Thomas, Jr., MD, W. Kevin Thomas, MD, Ralph A. Tillman, MD, James H. Tison, MD, Charles E. Todd, Jr., MD, Joel D. Todino, MD, L. Newton Turk, III, MD, J. R. Turner, MD, Charles R. Underwood, MD, Theodora Vanderzalm, MD, Emmerich Von Haam, MD, Minor C. Vernon, MD, Edward Jones Waits, MD, R. D. Walter, MD, Lamar H. Waters, MD, Alexander H. S. Weaver, MD, William H. Whaley, MD, Richard A. Wherry, MD, James Q. Whitaker, MD, Dan H. Willoughby, MD, S. Angier Wills, MD, William A. Wolff, MD, Betty B. Wray, MD, John Thomas Youger, MD, Neal F.Yeomans, MD.

Alternate Delegates: Larry Brightwell, MD, Luther E. Brown, MD, Carson B. Burgstiner, MD, L. T. Crimmins, MD, Harry N. Dorsey, MD, Lawrence L. Freeman, MD, David J. Frolich, MD, Ridley M. Glover, MD, John R. Grant, MD, James R. Hattaway, MD, E. V. Herrin, MD, Anthony F. Isele, MD, G. A. Johnston, MD, William F. Keeton, MD, Rene A. Morell, MD, Fred M. Rankin, Jr., MD, Beverly B. Sanders, Jr., MD, Hugh S. Thompson, Jr., MD

Appointments of Committees

The Speaker announced the appointments of the House of Delegates Reference Committees, Credentials Committee, and Tellers Committee as follows:

Reference Committee A: E. M. Molnar, Columbus, Chairman; Stephen Boyle, Conyers, Vice Chairman; Carl V. Hancock, Jr., Albany; J. Moultrie Lee, Savannah; Rodney M. Browne, Macon; Virendra Saxena, Fort Gaines; Harry Porter, Marietta; Joe B. Massey, Atlanta.

Reference Committee B: Richard W. Cohen, Austell, Chairman; James P. Evans, Savannah, Vice Chairman; William Bird Jones, Gainesville; Patton P. Smith, Forsyth; James L. O'Quinn, Augusta; James Q. Whitaker, Warner Robins; Alvin H. Clair, Atlanta; Dan B. Stephens, Marietta.

Reference Committee C: Robert Logan, Savannah, Chairman; Charles Lanford, Macon, Vice Chairman; S. Boyd Eaton, Decatur; Joseph M. Almand, Jr., LaGrange; E. Van Herrin, Athens; William A. Wolff, Columbus; Ralph Tillman, Decatur; James L. Askew, Riverdale.

Reference Committee D: William R. Hardcastle, Decatur, Chairman; Philip Z. Israel, Marietta, Vice Chairman; William Whaley, Atlanta; Robert B. Quattlebaum, Jr., Savannah; Alva Louie Mayes, Jr., Macon; Joel Todino, Rome; A. D. Muse, Jr., Athens; Carey W. Goodman, Jr., Statesboro.

Reference Committee F: Cyler D. Garner, Gordon, Chairman; C. Peter Lampros, Toccoa, Vice Chairman; C. Emory Johnson, Jr., Macon; Archie J. Morris, Vidalia; Luther M. Thomas, Jr., Augusta; Hugo S. Moreno, East Point; Marvyn D. Cohen, Columbus; Roland Summers, Savannah.

Reference Committee on Constitution and Bylaws: Richard Dubois, Atlanta, Chairman; LaMar S. McGinnis, Jr., Decatur, Vice Chairman, Alexander H. S. Weaver, Macon; Robert A. Lipson, Marietta; John B.



Dr. Joe Stubbs, delegate from Valdosta, ponders on House affairs. Dr. Milton Johnson, from Macon, is behind on the right.



(L to R) Dr. James E. Averett, Jr., delegate from Atlanta, and Mr. Bob Berg and Mr. Dick Vincent, MAG's legal counsel.

Rabun, Savannah; H. Gordon Davis, Jr., Sylvester; Neal F. Yeomans, Waycross; Chappell A. Collins, Jr., Albany.

Tellers Committee: Joseph T. Christmas, Vienna, Chairman; Minor C. Vernon, Macon; Walter R. Voyles, Waynesboro.

Credentials Committee: Milton I. Johnson, Jr., Macon, Chairman; Walker L. Ray, Clarkston.

Parliamentarian: Jack A. Raines, Columbus.

Adoption of Minutes

The Proceedings of the 1983 Meeting of the MAG House of Delegates as published in the June, 1983, *Journal of the Medical Association of Georgia* were approved.

Nominations

Speaker Menendez called on the House to proceed with nominations for the Officers, AMA Delegates, and the AMA Alternate Delegates.

Election of Unopposed Candidates

It was agreed at the outset that unopposed candidates would be elected at this session and the names of the candidates who have opposition be included on the ballot for election, Saturday, April 28, 1984.

Upon nominations duly made and seconded as indicated below, the following slate of officers was presented:

President-Elect: William D. Logan, Jr., Atlanta, was nominated for President-Elect by Ed Evans and seconded by Joe C. Stubbs, Valdosta.

First Vice President: John D. Watson, Columbus. Second Vice President automatically moves to First Vice-President.

Second Vice President: Joseph P. Bailey, Augusta, was nominated by William Barfield, Richmond County, and seconded by James H. Sullivan, Columbus.

Secretary: John T. Yauger, Atlanta, was nominated by Jeffrey T. Nugent, Atlanta, with a voice second from the floor.

Treasurer:

1) Charles R. Underwood, Marietta, was nominated by Frank McKinnon, of Marietta, with seconds by Charles D. Hollis, Albany, and H. Hilt Hammett, LaGrange.

2) Cyler D. Garner, Gordon, was nominated by Rodney Browne, Macon, with seconds by Quentin Price Dublin, and Virgle W. McEver, Warner Robins.

AMA Delegate seat presently held by Harrison L. Rogers, who is not seeking re-election: Carson B. Burgstiner, Savannah, nominated for a two-year term by Julian K. Quattlebaum, Jr., Savannah.

AMA Delegates: J. Dan Bateman, Albany, to succeed himself for a two-year term, nominated by Charles D. Hollis, Jr., Albany; H. Hilt Hammett, Jr., LaGrange, to succeed himself for a two-year term, nominated by J. R. Turner, LaGrange; Charles D. Hollis, Albany, to succeed himself for a one-year term, nominated by Frank Middleton, Albany.

AMA Alternate Delegates: Joseph C. Stubbs, Valdosta, to succeed himself for a two-year term, nominated by J. Robert Logan, Savannah; S. William Clark, Jr., Waycross, to succeed himself for a two-year term, nominated by Neal F. Yeomans, Waycross; L. Newton Turk, III, Atlanta, to succeed himself for a one-year term, nominated by Jeffrey T. Nugent, Atlanta; James H. Sullivan, Columbus, to succeed himself for a two-year term, nominated by Jack Raines, Columbus; C. Peter Lampros, Toccoa, to succeed himself for a one-year term, nominated by A. Delone Muse, Jr., Athens. AMA Alternate Delegate for seat vacated by Carson B. Burgstiner, Savannah: Virgle W. McEver, Warner Robins, was nominated for a two-year term by James Q. Whitaker, Warner Robins.

There being no further nominations, nor any expressed intention to mount a write-in campaign for any of these officers, the Speaker declared all unopposed candidates for President-Elect, Second Vice-President, Secretary, AMA Delegates, and Alternates closed.

Directors and Alternate Directors

Speaker Menendez announced the results of the elections for Directors and Alternate Directors as conducted by the District Medical Societies and Component County Medical Societies:

Bibb County Medical Society:
Director: Beverly B. Sanders, Macon
Alternate Director: Charles Lanford, Macon

Cobb County Medical Society:
Director: Dan B. Stephens, Marietta
Alternate Director: Ronald Roper, Marietta
Clayton-Fayette County Medical Society:
Director: Selwyn T. Hartley, Riverdale
Alternate Director: F. Peter Nicholson, Riverdale
DeKalb Medical Society:
Director: H. Duane Blair, Decatur
Alternate Director: Charles W. McDowell, Decatur
Floyd-Polk-Chattooga County Medical Society:
Director: Robert A. Farrell, Rome
Alternate Director: Joe D. Todino, Rome
Medical Association of Atlanta:
Director: J. Harold Harrison
Alternate Director: William C. Waters, Atlanta
Richmond County Medical Society:
Director: Luther M. Thomas, Augusta
Director: James L. O'Quinn, Augusta

Annual Reports

Speaker Menendez called for the Annual Reports of the MAG Officers, Directors, Committees, Departments, and other reports to be introduced at this Session. These are listed below with the Reference Committee to which these reports were referred:

Officers' Reports

President — F
Immediate Past President — F
First Vice President — Not Referred
Chairman of the Board — Not Referred
Secretary — Not Referred
Treasurer — F

Directors' Reports

First District Society — Not Referred
Second District Society — Not Referred
Third District Society — Not Referred
DeKalb Medical Society — Not Referred
Sixth District Society — Not Referred
Seventh District Society — Not Referred
Eighth District Society — Not Referred
Ninth District Society — Not Referred
Tenth District Society — Not Referred
Bibb County Society — Not Referred
Cobb County Society — Not Referred
C. W. Long Society — Not Referred
Dougherty County Society — Not Referred
Floyd-Polk-Chattooga County Society — Not Referred
Georgia Medical Society — Not Referred
Hall County Society — Not Referred
Muscogee County Society — Not Referred
Richmond County Society — Not Referred

Committee Reports

Access to Health Care — A
Auxiliary — Not Referred
Building and Land — Not Referred
Cancer and Cancer Advisory Subcommittee — Not Referred
Committee on Committees — C&B
Computer Advisory — Not Referred
Constitution and Bylaws — C&B
Cost Awareness — Not Referred
Education — D
Impaired Physicians — Not Referred
Legislation — C
Liaison with Medical Assistants — D
Maternal & Infant Health — A
Medical Aspects of Sports — A
Medical Practice — B
Medicine & Human Values — D
Membership Insurance — A
Nursing — Not Referred
Physicians Assistants — A
Physician-Lawyer Liaision — Not Referred
Prison Health Care — Not Referred
Public Health — Not Referred
Public Relations — A
Scientific Assembly — D
Third Party Relations — B
Computer Education — A
Occupational Health — C

Departments

Journal — Not Referred

Special Reports

MAG Mutual — Not Referred
Interspecialty Council — A
Auxiliary — Not Referred
AMA Delegation — Not Referred
GaMPAC — C

New Business — Resolutions

The Speaker proceeded to new business by calling for the introduction of Resolutions (Res.) which were assigned to Reference Committees as follows:

Res. 1: Athletic Injuries — A
Res. 2: Repeal of DRGs — B
Res. 3: Medical Student Section of MAG — C&B
Res. 4: Safety on Horseback — A
Res. 5: Smoking — A
Res. 6: Amendment to the MAG Constitution & Bylaws — C&B
Res. 7: Employer's Violation of Patient Confidentiality with Group Medical Insurance Claim Forms — B
Res. 8: Cognitive Services Reimbursement — B
Res. 9: Medical Staff Privileges — C
Res. 10: Reimbursement for Supervision of Intravenous Antibiotic Therapy in the Home — B
Res. 11: Advertising of Hospital Services — B
Res. 12: Freezing of Physicians' Fees — B
Res. 13: Mandatory Fee Assignment — C
Res. 14: Human Life — D
Res. 15: Physician Manpower Oversupply — D
Res. 16: Voluntary Freeze on Physicians' Fees — B
Res. 17: Liability Insurance Coverage for Treatment of State Health Department Patients — A
Res. 18: Professional Liability Tort Reform — C
Res. 19: Fee Freeze — B
Res. 20: Fee Freeze — B
Res. 21: Participating Physicians' Plans and Preferred Provider Organizations — C
Res. 22: Hospital Staff Privileges — B
Res. 23: Cost Containment — C
Res. 24: Endorsement of Indemnity Plans — B
Res. 25: Restructuring — A
Res. 26: Health Care Costs — B

Res. 27: Composite State Board of Medical Examiners' Rules and Laws Information — C
Res. 28: Opposition of NCI List of Physicians with "Expertise" in Cancer Care — D
Res. 29: Recommendations to SHPDC — D
Res. 30: Statute of Limitations — C
Res. 31: Memoralizing Lawrence P. McDonald — C
Res. 32: Generic Drug Substitution — C
Res. 33: Physician Fees — B
Res. A: Affiliate Membership for James D. Anderson, DDS — A

At 9:35 PM, following several announcements, the Speaker declared the House in recess until Saturday, April 28, 1984 at 9:00 AM.

Unreferred Reports

Reports which did not have any recommendations were not referred to any Reference Committee. All such unreferred reports were filed for information. They are as follows:

First Vice President

Eloise B. Sherman, M.D.

It has been my pleasure to have served as your Vice President for the last two years. As I complete my term as First Vice President this year, I am pleased to report that the Medical Association of Georgia, representing more than 5,500 of the state's physicians, is healthy and growing.

The MAG with a staff of nearly 30 stands ready to meet the challenges ahead, and physicians have the opportunity, privilege, and *obligation* to set the agenda for the future of medicine as it will be practiced for generations to come.

The challenges are many: expanding regulatory and legislative jurisdiction, cost containment pressures, significant statistical increases in longevity and therefore our aged population, hostility toward the profession emanating from the media, legal profession and, yes, even from the public, our patients, only to list a few. This environment virtually mandates a strong, *active* commitment to collective efforts through our organized medicine outlets, such as our county medical societies and the MAG. Although a cliche, never before has the quotation "Together we stand . . ." been more critical than now.

The MAG is involved in a number of activities of which we can be very proud. MAG's Physician Involvement Program of "PIP" is recognized as one of the most effective and rewarding in getting legislators and physicians acquainted with one another and in educating physicians about the legislative process and most importantly, *how to influence* it.

MAG's Impaired Physicians Program, created almost a decade ago and recognized both nationally and internationally, has served as a prototype for medical and other professional organizations country-wide.

Your MAG Board of Directors and Executive Committee, plus some 40 committees represent hundreds of physicians volunteering their time and encouraging all members, men and women, young and old, active and retired, *to get involved.* All of these endeavors are catalyzed by a dedicated, superior, and professional administrative staff, the largest in the history of the Association.

Looking ahead, MAG's organized public relations efforts, while admittedly starting in each of our offices, will attract favorable media attention to our commitment to preserving quality medical care without compromise.

The Operation Care programs in Atlanta, Columbus, Athens, Savannah, Augusta, and Albany are examples of unified endeavors responding to critical public needs.

By the nature of our zealously guarded independence, outside regulatory agencies patiently sit on the sidelines and gleefully predict our demise — through our own apathy and inertia. We are the last free-thinking men and women with extended significant influence through our patients, our families, and our time-honored institutions. While Rome burns, where will you stand, doctor? Oh yes, it can happen.

Thank you for the opportunity to have served as your Vice President these past two years. It is an honor and an experience that I shall never forget.

Chairman of the Board

Joe L. Nettles, M.D.

Your Board of Directors is the executive body of the House of Delegates, and between sessions of the House of Delegates, shall exercise the powers conferred on the House by the Association's Constitution and Bylaws.

Currently, the Board of Directors is composed of 32 members and 21 alternates. These 32 individuals represent the officers of the Association, 8 district directors, and 13 directors representing 11 county medical societies that have more than 100 members of MAG.

County medical societies are entitled to direct representation on the Board as follows: 100-399 members, one delegate and alternate; 400-499 members, two directors and alternates; 1,000 or more members, three directors and alternates.

I am pleased to report that two additional directors and two alternates will be added to the Board, following this House of Delegates. The Richmond County Medical Society, which currently has one director and alternate, will now have two directors and alternates as that society exceeds 399 members.

The Clayton/Fayette Medical Society will be represented by one delegate and alternate as that society has more than 100 members.

Your Board meets quarterly, usually in June, September, January, and right before the annual meeting, in April.

Your Board this year has tackled some very serious problems and concerns to the Association, e.g., free-standing medical clinics, the cost of medical care, preferred provider organizations (PPOs), the Federal Trade Commission (FTC), health maintenance organizations (HMOs), evaluating the possible sale of the MAG headquarters, etc. Many of these matters will be brought before this House in various committee and officer reports as well as resolutions.

The challenges facing medicine today are many and varied. Perhaps the greatest is providing top quality care at a cost that is affordable. The federal government has changed direction from primarily being concerned with everyone receiving access to care to limiting costs which will surely limit that same care.



Serving on MAG's Board of Directors which met before the Annual Session began (L to R) Drs. William D. Logan, Jr., Atlanta, Secretary; William W. Moore, Jr., Atlanta, President; Joe L. Nettles, Savannah, Chairman of the Board; and S. William Clark, Jr., Waycross, President-Elect.



Also serving on MAG's Board of Directors are (L to R) Drs. Alva L. Mayes, Jr., Macon; Charles D. Hollis, Jr., Albany; Bob G. Lanier, Atlanta; and William M. Headley, Milledgeville.

DRGs — diagnosis related groups. There isn't a physician that will not be affected by the program represented by these initials. The whole idea which was originally a research tool at Yale University back in the '70s is rapidly becoming the standard for pricing in the '80s. DRGs do not represent prospective payments but prospective pricing. The government has found a way to effectively price hospital services. The tragedy of DRGs is that it will ultimately be the patient, not the physician, who suffers. It will not be long before attempts are forthcoming for DRGs to expand to not only cover Medicare patients and hospitals' reimbursements but to cover other patients and probably physicians' services as well.

Another response to the increasing costs in the medical and health care marketplace is the preferred provider organizations (PPOs). Many PPOs have developed in communities which have recently experienced a growth in local HMOs or health maintenance organizations.

Physicians are faced with weighing the advantages and disadvantages of joining a PPO if the PPO is available in his area. The big advantage of joining a PPO is the maintenance of the fee-for-service office-based practice.

A disadvantage is the potential loss of autonomy and the necessity of accepting control mechanisms into which the physician may have no input.

Another effort of providing more cost effective health care is the creation of the business coalitions. Several in Georgia have been formed. The proper idea is that business, providers, and others would join hands to mutually attempt to come to solutions to the problem of rising health care costs. In some communities business has attempted to dictate its demands without input from the local medical society. In these instances, the quality of medical care may be compromised and the medical community may be placed in a fragmented and competitive position. MAG encourages county medical societies to consider becoming members of such coalitions in their communities, so that they may have a part in directing such efforts from their very onset.

The physician population is growing and growing rapidly. Competition among physicians, particularly in the urban areas, is being felt as never before. Some physicians are beginning to market their services. Hopefully, we will not abandon our ethical beliefs in advertising our services as if they were in the category of used cars and food processors.

I can say with pride that the MAG is addressing these issues and many others. Our Leadership Conference in January was attended by hundreds of our colleagues from all across the state.

We have sponsored workshops on risk management, using computers in your practice, physician/attorney relations, current trends in health education, continuing medical education, marketing, etc.

We have addressed the problem of rising medical and health care costs by asking all Georgia physicians to freeze their fees for one year and to accept reduced fees for those in need.

The MAG is your Association with a budget approaching two million dollars and a staff of nearly thirty.

Your Board has and will always attempt to represent our members in carrying out the two objectives of the Association: the advancement of the art and science of medicine and the betterment of the public health.

Your Board of Directors can only represent you if we know how you feel concerning a given issue. Get to know your Board member(s). As Chairman, I welcome the opportunity of hearing from you on how the Board can better serve your needs.

Secretary

William D. Logan, Jr., M.D.

Your Secretary's Report this year is one mostly of reflection. A thoughtful review of the past six years fills me with feelings consisting of some regret but mostly of pride and appreciation. Yes, I am proud to have been a part of the Medical Association of Georgia and have come to appreciate the tremendous efforts of the many officers, staff, and others who have contributed to the continuing of this great Association.

Our membership continues to grow. We now have five and one half thousand members that represent all phases



(L to R) Drs. William M. Headley, Milledgeville; Charles E. Wills, Jr., Washington; James L. O'Quinn, Augusta; and Luther M. Thomas, Jr., Augusta, serving on MAG's Board of Directors.

of medicine in Georgia. Our involvement with the students, interns, and residents has increased greatly and indicates a continued involvement as these young men and women take their place in practice. Truly, I believe MAG represents the best interests of all the doctors of our state.

Our committee structure has been re-designed and will be presented at the Annual Session. It is my firm belief that this change will strengthen our working force.

We have been asked, and have participated, with the leadership roles in many social, political, and economic endeavors. Perhaps some mistakes have been made, but in general, we have succeeded in maintaining our integrity and continue as the most respected profession.

Aside from the routine administrative tasks and regular committee activities, the MAG has contractual arrangements with the Georgia Medical Care Foundation for its computer needs; the State of Georgia for the Georgia Cancer Registry and the Prison Health Care Program; and the Appalachian Regional Program for a physician recruitment program.

Information relating to the Georgia Medical Care Foundation and to the computerized activity required for the Cancer Registry is included in the report filed by the Computer Advisory Committee established this year to coordinate activities of the Information Systems Department. Activities of the Prison Health Care Program are reported in the Prison Health Care Committee report. The Physician Recruitment efforts are reported in the Access to Health Care Committee Report.

The Georgia Cancer Registry: The Georgia Cancer Registry continues to operate under a contract from the Georgia Department of Human Resources. Thirty-seven Georgia hospitals participate in the program by submitting information on newly diagnosed cancer cases seen in their facilities, plus on-going follow-up information on cases already in the data base. Supplemental money received in March, 1983, has been used to update the data collection forms in order to reflect changing coding systems and to incorporate a change in the core data base as required by the American College of Surgeons, Commission on Cancer, for an approved Hospital Cancer Program. This supplemental money was also used to move all data processing for the project to Information Systems at the MAG. The contract for the Georgia Cancer Registry will be renewed in July, 1985, in the amount of $107,000.

Let me again express my great appreciation to the officers, members of the Board, and staff for the support given to me over the past six years. It has truly been a great time for me.

Journal of the Medical Association of Georgia

Edgar Woody, M.D., Editor

Content

During the 1983-84 year, we have continued to be responsive to the needs and desires of our readers. High on our list of priorities have been better approaches to cost control both at the hospital and office practice levels. Special issues have featured the Auxiliary of the MAG, Operation Care, and an editorial and cover article about "Who Is To Control Our Fees?," the doctors or insurance companies. Another issue was devoted to the GaMPAC program. The MAG Leadership Conference was featured on the November cover with an accompanying special article. And the treatment of hypertension was featured in another recent issue.

Credits

Our contributing editors have continued to be very helpful in the solicitation and review of scientific material for publication. The Executive Committee of our Board of Directors, which also functions as the Publications Committee, continues to serve in its vital role as the final arbiter in matters of *Journal* policy. The Georgia Chapters of the American Cancer Society and the American Heart Association have maintained their usual high standards in the screening of quality material for their respective specialty pages.

Our cover artists this past year, Richard Lyons and Richard C. Hagerty, M.D., have designed some very attractive illustrations which have enhanced the appearance of our publications.

The numerous contributions and helpful advice given by the members of the Headquarters office staff should be pointed out. Without their continuing input, the *Journal* could not adequately reflect the numerous activities of the Association.

The excellent contributions of Dr. William Moore "President's Letters" have been cogent and timely.

The Legal Page, authored primarily by Robert N. Berg, has kept us informed regarding timely legal issues that relate to our practices.

Personnel

Happily, there have been no changes in personnel connected with the *Journal* in the past year. I believe we have a winning team and hope to keep it that way.

Local Advertising

Our managing editor is continuing to assume the responsible role in the administrative aspects of the local advertising program. As of this writing (February), income from local ads has increased by 10.4% over last year's at the same time. We have also been successful in holding down our production costs by limiting the size of the editorial portion of the *Journal*. We are continuing to encourage the members of the Headquarters Executive Staff to solicit ads. We also welcome any ads solicited by the members of the Medical Auxiliary.

National Advertising — State Medical Journal Advertising Bureau

Since last year, our billing revenues through the

National Advertising Bureau have dropped by 16.8%. Other state journals across the country have been similarly affected. The Williams & Wilkins Company of Baltimore has had the responsibility as the sales force for the Bureau for the past 7 years. Because of Williams & Wilkins declining productivity, the Bureau's Board of Directors decided to terminate their contract with them and to engage the services of a new sales force. Most of us are optimistic that this new sales force will be able to turn the tide in the direction of increased billing revenues for our group. Your editor is continuing to serve as a member of the Board of Directors of the Bureau.

In spite of the fact that the combined billings of the Bureau are down at this time, the *Journal of the MAG* is ranked number 2 among the Bureau's 32 member state journals in terms of total national advertising pages.

MAG Mutual Insurance Company

Charles D. Hollis, Jr., M.D., President

The date was June 1, 1982. The Medical Association of Georgia gave birth to a healthy new addition to organized medicine in Georgia. MAG Mutual Insurance Company was born, joining 28 other physician-owned companies in the United States.

The remainder of 1982 was spent in building a solid foundation for your company. At year end, a professional group of employees had been assembled, and a strong financial base had been built.

As we look at 1983 results, your company is obviously on the road toward a robust, successful adult life. Here are some of the key numbers representing your company's 1983 achievements:

	Actual	*Planned*
Annual Written Premiums	$8,813,720	$8,700,000
Losses-Received and Paid	4,185,153	6,171,000
General & Administrative Expense	1,816,505	1,582,676
Investment & Other Income	883,398	1,050,000
Profit (Loss)	(91,549)	(202,000)
Physicians Insured	1,710	1,650

As you can see, we missed our plan on a couple of counts primarily because budgeting was very difficult with no prior history upon which to base expenses. In addition, we decided to invest the necessary funds to install a new computer system that is now operational. The important point is that we were able to produce a near break-even bottom line! Considerably better than planned.

Numbers, of course, tell only part of the story.

Here are some additional highlights:

- Your agency, MAG Mutual Insurance Agency, Ltd., formed in December, 1982, and wrote $141,773 in premiums. This is a wholly owned subsidiary of your company and now offers a complete line of competitive property and casualty products for your "other than professional liability" insurance needs.
- Largely through MAG Mutual efforts, a Governor's Advisory Council on Medical Malpractice was formed with Dr. Hollis as Chairman. The council completed its first phase of deliberations in January, 1984, but was still able to get two important pieces of legislation passed in the 1984 legislative session. Plans are in place to do more next year.
- We began a vital long range planning activity in 1983. This is ongoing and will be of great future benefit to your company.
- Our new data processing is now operational. 1984 will see some great benefits of this system in increased efficiencies and management information.
- For the first time, MAG Mutual rates reflect our own expense ratios and because of this our 1984 rate levels are 5% to 9% below our principal competition.
- A loss prevention-risk management function was started in 1983 and will continue to assist in loss reduction this year and beyond.
- We now have 28 professional, dedicated people to serve your needs. During 1984, we are planning no expansion in personnel — other than in the claims organization.

Some highlights of our 1984 planned results are:

	1983	*1984 Plan*	*% of Change*
Written Premiums	$8,813,720	$14,400,000	63.4
Losses Received and Paid	4,185,153	7,922,050	89.3
General & Admin. Expenses	1,865,505	1,823,674	(2.2)
Investment & Other Income	883,398	1,525,000	72.6
Profit (Loss)	(91,549)	484,826	+ + + +
Physicians Insured	1,710	2,400	40.4

As of mid-March 1984, we have 1,800 physicians insured, so we are on course for the year.

As of mid-March 1984, we have received 437 reports of claim or incidents since inception June 1, 1982. Over 100 of these have been closed, leaving 327 pending claims.

Your assets now amount to approximately $12,500,000 and our investment yield is still in excess of 11%. Most of the invested assets are in U.S. Treasuries.

Finally, the medical community in Georgia can be justly proud of its company. In addition, some well deserved applause should go to the eighteen Directors and two non-Directors serving your company on the board and various committees. The time they devote on behalf of organized medicine and the dedication they bring is truly remarkable.

Auxiliary to the Medical Association of Georgia

Mrs. George R. Jones

Theme for 1983-84: "We Care"

Organization

Forty-seven county auxiliaries encompassing 105 counties: Baldwin, Barrow, Bartow, Bibb, Camden-Charlton, Carroll-Haralson, Cherokee-Pickens, Clayton-Fayette, Cobb, Dougherty, Flint, Floyd-Polk-Chattooga, Franklin, Georgia Medical, Glynn, Gordon, Gwinnett-Forsyth, Hall, Hart, Jackson-Banks, Laurens, Lumpkin,

Medical Association of Atlanta, Muscogee, Newton-Rockdale, Ogeechee River, Peach Belt, Randolph-Stewart-Terrell, Richmond, South Georgia, Stephens-Rabun, Sumter, Thomas Area, Tift, Troup, Upson, Walker-Catoosa-Dade, Ware, Wayne, Whitfield-Murray, and Worth.

Membership

As of March 14, 1984, membership is 2,258.

President visited and spoke to the auxiliaries on Operation Care, Nutrition, Phase II, of the Learning Center, and showed a slide presentation on the installation of Glenda Bates, AMA Auxiliary President from Georgia.

Allied Organizations Visited

AMA Auxiliary Convention in Chicago, AMA Leadership Confluence Meeting in Chicago, MAG Legislation Seminar at Amelia Island.

Materials Implemented or Continued

1. Learning Center Brochure
2. *Pulsations* Newsletter
3. Auxiliary Issue of MAG *Journal*
4. 23 Auxilian appointments to MAG Committees
5. Phase II — Nutrition — added to Educational Learning Center.

State Meetings and Speakers

Post-Convention Executive Board Meeting, Columbus; April 23, 1983.

Summer Executive Board Meeting and Workshop, Augusta: Lt. Governor Zell Miller, Speaker, on Political Process and Mr. Ken Williams, MAG, on Operation Care.

Winter Executive Board Meeting, Terrace Garden Inn, Atlanta. Speakers: Dianne Leeb, M.D., Plastic Surgeon, and Ann Rigas, County Commission Chairman.

Allied Health Careers Clubs of Georgia — Annual meeting will be April 12-14, 1984. There are 12 clubs and we are also working this year with the 144 Health Professional Schools across the state.

Annual Convention, Atlanta; April 27-28, 1984. Speakers: Mrs. John G. Bates, AMA Auxiliary President, Mrs. William J. Reardon, SMA President, Dr. Joseph Boyle, AMA President-Elect, and Frances Patton Statham, Author.

President Visited: Baldwin, Bibb, Carroll-Haralson, Cherokee-Pickens, Clayton-Fayette, Cobb, Coweta, Crawford W. Long, DeKalb, Dougherty, Floyd-Polk-Chattooga, Franklin, Medical Association of Atlanta, Muscogee, Newton-Rockdale, Peach Belt, Randolph-Stewart-Terrell, Richmond, South Georgia, Sumter, Tift, Walker-Catoosa-Dade, Ware and Whitfield-Murray. Also attended the Personal Growth Seminars held in Atlanta, Athens, and Albany.

Projects — State

Operation Care — a joint effort with MAG.

AMA-Education and Research Foundation Fund Raising Drive: Selling Gift Wrapping Paper — a new project this year: $3,406.

Auction at Winter Board Meeting — $1,057.50. To date, the A-MAG has contributed $19,955 to AMA-ERF.

The Christmas Board Sharing Card amounted to $980, with 47 Executive Committee members participating.

Health Education Project — Phase II, Nutrition, of the Learning Center. It has been shown or portions purchased by sixteen (16) different areas and three complete Nutrition sections were purchased by Cobb, Muscogee, and Floyd-Polk-Chattooga Auxiliaries.

The William R. Dancy M.D. Student Loan Fund had contributions totaling $3,721.50 from the 15 counties participating.

Contributed household items, as well as funds, to the Impaired Physicians Program.

Drugs and supplies were contributed to the hospitals in Bogota, Colombia.

Day at the Capitol honoring legislators with special recognition given Glenda Bates, AMA Auxiliary President.

Publications

Book: *History of The Medical Profession in Georgia, 1733-1983*, authored by Mrs. Brit B. Gay, released in November 1983, with sales going well.

The Directory — distributed to every A-MAG member.

Annual Report with each county auxiliary's activities for the year included.

Pulse Line — (three issues) mailed to all members.

Pulsations — Newsletter (four issues) mailed to all members.

Educational Learning Center Brochure (distributed to schools and organizations to encourage health education).

Projects — County

The Auxiliary's greatest strengths are in the counties and the projects they do to fulfill the needs of the communities. The county auxilians also participate in state projects.

The County Auxiliaries are involved in MADD programs, Operation Care, Infant Car Seat Loaner Programs, and projects of the Aging; meals programs, nutrition, blood banks, Children and Youth; child abuse shelters, GEMS, hospital orientation, Family Life, child birth education, death and dying, family planning, parenting, Health Careers, sponsoring Allied Health Career Clubs, Health Fairs, giving scholarships, Health Education: Alcohol and drug abuse, immunization, organ donations, public seminars, Learning Center, school curriculum, sex education, Health Services: Emergency Medical Care, language bank, Vial of Life, International Health collection of drugs and supplies. Safety: Bicycle, infant/child car restraint, poison prevention; screening for hearing, vision defects, scoliosis, hypertension, immunization, learning disabilities, Shape Up For Life through nutrition, physical fitness and stress management, total body.

The County Auxiliary is there to help in the community wherever or whenever the need arises. Untold hours are spent every year by this statewide network of volunteers called the Medical Auxiliary.

We are also fortunate to have 23 auxilians appointed to MAG committees.

The MAG Advisory Committee on Auxiliary consisting of 10 members (all physicians) has been most helpful to the Auxiliary.

AMA Delegation

C. Emory Bohler, M.D., Chairman

Delegate's Report — 1983 Interim Meeting of the AMA House of Delegates

Introduction

The AMA House of Delegates met in Los Angeles December 4-7, 1983.

There were 351 delegates seated:

— 281 delegates representing state medical associations
— 61 delegates representing national medical specialty societies
— 9 Section and Service delegates representing medical students, medical schools, resident physicians, Army, Navy, Air Force, USPHS, and the Veterans Administration.

In addition, the following organizations sent "Official Observers" who have a non-voting seat in the House:

American Dental Association
American Hospital Association
American Group Practice Association
National Medical Association

Also, the House voted to invite the American Medical Women's Association to send an "Official Observer" to future meetings.

The Secretary of the Department of Health and Human Services, Margaret Heckler, addressed the House of Delegates on health care costs and the government's ever increasing role in health care through Medicare and Medicaid payments.

Joint Commission on Accreditation of Hospitals (Resolutions 45 and 77)

JCAH medical staff provisions continued to dominate the discussion at the House of Delegates.

Two broad issues under consideration were:

1. Physician responsibility for patients admitted to hospitals by limited licensed practitioners.
2. The ability of the individual hospital and medical staff to determine which categories of limited licensed practitioners may be considered for medical staff membership.

After lengthy debate on the serious legal and patient care implications involved with these issues, the House adopted the following policy statement:

> That it be the policy of the American Medical Association that the hospital medical staff may grant admitting privileges to appropriately credentialed limited licensed practitioners in accordance with state law and *in accordance with the criteria for standards of medical care established by the individual hospital medical staff.*
>
> That it be the policy of the American Medical Association that hospital admitting privileges be granted in accordance with state law and in accordance with criteria for standards of medical care established by the individual hospital medical staff.

The Insanity Defense in Criminal Trials and Limitations of Psychiatric Testimony (B of T Report G and Substitute Resolution 75)

The House adopted a report of the Board pertaining to insanity as a defense which received generally favorable attention among members of the news media. The report called for a narrowing of the use of the insanity defense in criminal trials.

The American Bar Association and the American Psychiatric Association expressed opposition to the report which concluded that the insanity defense:

> "Has outlived its principal utility, it invited continuing expansion and corresponding abuse, it requires juries to decide cases on the basis of criteria that defy intelligent resolution in the adversary forum of the courtroom, and it impedes efforts to provide needed treatment to mentally ill offenders."

The Reference Committee concluded that the position recommended by the Board is:

— Rational and thorough in all aspects.
— Will decrease the time and costs involved in criminal trials.
— Will provide greater opportunity for appropriate treatment of the mentally ill.

The House also called upon the AMA Board to continue collaborative efforts with the ABA and APA to achieve a common policy position concerning the insanity defense.

Indemnity Versus UCR (CMS Report B)

The House amended then approved a major report regarding physician reimbursement by means of indemnity versus UCR. This issue was first introduced at the 1983 Annual Meeting and the House called for further indepth study of the positive aspects of indemnity schedules.

In amending the report, the House reaffirmed Association policy supporting:

— Freedom for physicians to choose the method of payment for their services and to establish fair and equitable fees.
— Freedom of patients to select their source of care.
— Neutral public policy and fair market competition among alternative health care delivery and financing systems.

Another report is anticipated for the 1984 Annual Meeting.

Balance Billing (Resolution 128)

In a related action the House voted to:

> "Support the right of the physician to balance bill a patient for any care given, regardless of method of payment where permissable by law or contractual agreement."

DRG Based Prospective Payment (CMS Report J, Resolutions 70, 71)

The House filed a status report on regulations implementing the Prospective Payment System for Hospitals. In a related action, the House voted to:

— Endorse the concept that any system for reimbursement for physicians' services be independent of reimbursement systems for other providers of health care.
— Continue to oppose expansion of prospective payment systems until such time as they have been adequately evaluated with respect to their impact on the quality, cost, and access to medical care.

Medical Student and Resident Physician on the Board

The House approved a Constitutional amendment and new Bylaw language to provide positions on the Board of Trustees for a medical student and a Resident Physician.

— The Resident will be a voting member and the student will be non-voting.
— Two-year terms, maximum of three terms for the Resident member.
— The Resident will be elected by the House at the 1984 Annual Meeting.
— The student will be appointed by the Board annually.

The Medical Student Section has endorsed three candidates:

Alice Chenault, Alabama
Al Osbahr, North Carolina
Keith McManus, North Carolina

The Resident Physician Section has endorsed two candidates:

Ronald Davis, M.D., Illinois
Michael Anne Brown, M.D., California

Surrogate Mothers (J.C. Report C)

The House approved a Judicial Council report that concludes:

> "The Judicial Council believes that surrogate motherhood presents many ethical, legal, psychological, societal, and financial concerns and does not represent a satisfactory reproductive alternative for people who wish to become parents."

Confidentiality in the Physician/Patient Relationship (J.C. Report B)

The House approved another report of the Judicial Council pertaining to confidentiality between a physician and patient.

The report states that "The Physician should not reveal confidential communications or information without the express consent of the patient, unless required to do so by law." Exceptions are:

— When a patient threatens to inflict serious bodily harm on another person.
— Communicable diseases, gunshot and knife wounds should be reported as required by applicable statutes or ordinances.

While not mentioned in the report, the Chairman of the Judicial Council stated that incidences of child abuse and abuse of the elderly should also be reported to appropriate authorities.

Sale of Human Organs (Resolutions 16, 61, 78, 87)

The House voted to:

— Oppose the sale of non-renewable, transplantable organs for the purpose of profit.
— Continue to monitor the legislation now being considered in Congress on this subject.

Care of Handicapped Newborns (Resolutions 23, 80, 86)

The House voted to:

— Continue to oppose regulations or legislation which would impose a federal role in the decision-making about the care of severely ill newborns.

Scientific Accuracy in Racial, Ethnic, and Religious Designations in Medical Records (Resolution 4)

The House voted to:

— Advocate precision in racial, ethnic, and religious designations in medical records with information obtained from the patient always respecting the personal privacy of the patient.

"Opium" Perfume (Resolution 20)

Responding to a resolution that discussed the appropriateness of naming perfumes and colognes after drugs, the House voted to:

— Oppose the advertising practice of naming products for controlled substances, implying that their use is exciting and desirable.

Cost and Financing of Medical Education and Availability of First-Year Residency Positions (CME Report A)

The Council on Medical Education submitted an extensive report on the following subjects:

— Cost and financing of medical schools.
— Medical students and their financial problems.
— Residency programs and the availability of first-year positions.

This comprehensive report contained 17 recommendations which were approved by the House.

Scientific Reports

The House considered many scientific reports prepared by the Council on Scientific Affairs. Topics included:

— Early Detection of Breast Cancer.
— Exercise Programs for the Elderly.
— Caffeine Labeling.
— A Physician's Guide to Asbestos-Related Diseases.

Conclusion

AMA House meetings provide a unique educational opportunity, and I would encourage you to attend and participate. Any member of the Association may present testimony at the Reference Committee hearings and, of course, corridor discussions on the issues provide ample opportunities to get your views across.

Georgia Medical Care Foundation

Luther M. Thomas, Jr., M.D., President

Each year the active interest in utilization review and quality assurance seems to expand. Not only are governmental agencies active in this arena but also businesses, both through coalitions of businesses and as individual entities. Competition to organizations such as ours continues to grow as well. Computer companies, insurance companies, and even other physician groups apparently see money to be made in utilization review, and therefore, are marketing systems. GMCF continues to work diligently to retain medical peer review in Georgia in the hands of the privately practicing physicians of Georgia.

PRO Program

It appears that the PRO program in Georgia will be initiated in July of 1984. GMCF has completed its bid for the PRO contract and anticipates its acceptance. It is

hoped that sufficient resources will be allocated to Georgia in order that the review system be as unobtrusive as possible and not be an impediment to high quality care and efficient claims processing.

MAG Computer Contract

During the year it was discovered that GMCF's needs in the area of data processing could not be accomplished on MAG's existing computer hardware. This was made known to the leadership of MAG and GMCF, and MAG worked closely to devise a new plan wherein GMCF's computer needs can be met while maintaining this excellent link between the two organizations. We believe that MAG has produced an excellent proposal which will serve our needs both in the PRO contract and in private industry as well.

Nursing Home Review

You may recall that last year at this time our nursing home review program was still in great danger of being eliminated from GMCF and transferred to the Department of Human Resources. This was at the instigation of the nursing home industry. We are pleased to report that during the past year, intensive efforts at determining what legitimate complaints the nursing home industry might have and opening lines of communication have successfully eliminated this threat. We therefore are continuing to do the nursing home review and expect to continue this process for the foreseeable future.

GMCF Officers — 1983/1984

President: Luther M. Thomas, Jr., M.D., Augusta
Vice President: Joseph M. Almand, M.D., LaGrange
Treasurer: Frank R. Miller, M.D., Thomasville
Secretary: John G. Bates, M.D., Cuthbert

Committee on the Auxiliary

George R. Jones, M.D.

The Advisory Committee to the Auxiliary held its first meeting in April, 1983, with six members in attendance. Another meeting was scheduled for August but was cancelled. Advice was rendered to the President and the Executive Board whenever requested.

Building and Land Committee

H. Duane Blair, M.D., Chairman

MAG's Executive Committee, on July 17, 1983, agreed in principle to consider the sale of the MAG building to MAG Mutual, subject of course to all the details being worked out to the satisfaction of both parties.

The situation is that MAG Mutual, from a tax standpoint, should own its own home office building. MAG, as a nonprofit corporation, does not enjoy the same tax privileges. Currently, MAG and MAG Mutual occupy separate buildings and MAG's Executive Committee and MAG Mutual felt both parties should be housed in the same structure. The MAG building is so constructed that it could be expanded to provide sufficient space for both MAG and MAG Mutual.

On October 28, an appraisal of the building and land on which the headquarters is situated was submitted by two MAI appraisers, Mr. V. Stuart Ward, Jr., and Mr. Frank B. Roberts, both of Atlanta. The leadership of MAG and MAG Mutual had previously agreed to use these appraisers and MAG and MAG Mutual would share the cost of the appraisal, an amount of approximately $5,000.

The MAG Executive Committee in November, 1983, charged the Building and Land Committee to evaluate the appraisal and to offer a recommendation that would best serve the Association.

The Building and Land Committee met on November 22, reviewed the appraisal which set the value of the MAG building and grounds at some $950,000, and agreed to make the following recommendation to the MAG Board in January, 1984:

> If a sale to MAG Mutual can be made which will protect MAG's equity and guarantee a long-term lease at no more than anticipated interest on the money received and the money received can be protected in some form of building escrow account, then the Building and Land Committee recommends such a sale. We further recommend that any such contract be evaluated by this Committee prior to consummation of the sale.
>
> As further explanation, an example would be as follows: If MAG sold the headquarters for $1,000,000, the principal would be placed in a separate escrow account. The rent charged to MAG by MAG Mutual (the new owner) should total no more than the interest on the $1,000,000. This would also assume that a long-term lease arrangement could be worked out.

The MAG Board of Directors, at its meeting of January 15, 1984, accepted as information the Building and Land Committee's report.

The Building and Land Committee stands ready to receive, evaluate, and make a recommendation on any proposal from MAG Mutual to purchase our headquarters building, assuming such offer is in the best interest of the Association.

Cancer Committee and Cancer Advisory Subcommittee

J. Moultrie Lee, M.D., Chairman

At the combined meeting of the Cancer Committee and Cancer Advisory Subcommittee in January, 1984, these committees reviewed and accepted the MAG public policies concerning cancer. This review was carried out at the request of the Board of Directors. Suggestions for revision of wording to express the present policies more accurately were accepted, but no change in any policy was made.

The lack of adequate funding for the Community-Based Cancer Control Program was discussed at length. The committees passed a motion that certain state legislation be approached directly in an effort to obtain their help in obtaining this funding. This approach was carried out but apparently to no avail.

The committees passed a motion that the MAG be requested to support the American Cancer Society, Georgia Division in its CHEC Colon/Rectum Program.

The Chairman wishes to express his sincere appreciation to the members of his committees for their continued interest, aid, and support during the past year.



(L to R) Drs. Charles H. Wray, Augusta, and Harrison L. "Jack" Rogers, Atlanta.

Computer Advisory Committee

John D. Watson, Jr., M.D., Chairman

The Computer Advisory Committee was created by the Executive Committee to review the Information Systems operation of the Association, to recommend any necessary changes, and to provide continuing oversight of this important function.

The investigative phase of the Committee's work was completed in the fall of 1983. The Committee found considerable dissatisfaction at some levels with the performance of our Information Systems staff; the bulk of this dissatisfaction was with the time required to complete programming development requests. But the Committee also found that once the staff delivered a product or service, the users of it were extremely well pleased. It is the developmental process that appears to be the big concern. The Committee has determined that the lengthy development times often encountered are due to insufficient staff resources caused by a failure to budget realistically for the Association's own data processing requirements. The Committee determined that hiring an outside firm to provide the computing services needed by the MAG would cost between $75,000 and $116,000 per year. By contrast, in previous years we have budgeted less than $20,000 each year to provide these services. The Information Systems budget for the coming year corrects this shortcoming.

The Committee is also concerned that our computing hardware is not sufficiently flexible to continue to meet the needs of the Association and related organizations, and the budget makes provision for needed capital improvements.

Finally, we have received an expression of concern from the Georgia Medical Care Foundation that our computer, which was designed to meet the needs of a small business, does not provide sufficient computational power to meet the research needs of the Foundation under the new Professional Review Organization contract, which will replace the PSRO in the coming year. Furthermore, only a few packaged programs designed for research are available for small business computers. To address these concerns, the Committee engaged the firm of Hyatt, Imler, Ott, and Blount to assess the needs of the Foundation under the PRO contract and advise us regarding how we could best prepare to meet them. Mr. Larry Ott presented us with the draft of his firm's report on March 16; he recommends the purchase of a Digital Equipment Corporation (DEC) VAX 11/750 computer and certain packaged software. The Committee met by conference call and voted to accept Mr. Ott's recommendation for action contingent upon making satisfactory financial arrangements with the Foundation to allow us to recover our costs within a reasonable period of time. Dr. Moore participated in the conference call meeting and has since been working with the president of the Foundation, Luther M. Thomas, Jr., MD, to make such arrangements.

At the time this report was prepared, in early April, no final conclusion has been reached, but steady progress toward an agreement was being made, and the chances for a positive conclusion appear very good. Similarly, no final decision on the exact configuration of hardware and software had been made, so the exact cost and the rate of return on the Association's investment cannot be computed. However, the fiscal aspects of this proposal will have been presented to the Executive Committee and Board of Directors prior to the meeting of the House.

By restoring our staff to its size in 1981 and increasing the flexibility of our equipment, we can continue to provide high-quality information systems support to the Association and related organizations, to provide such support in a timely manner, and to offer a high level of utility to those who depend on our computer to do their jobs. By adding hardware and software for scientific computing, we can help the Foundation maintain their position of leadership in the field of medical review.

Fiscal Note:

The cost of restoring our staff to its former size and improving our existing equipment is reflected in the budget of the Information Systems department. The financial details of the proposal to provide additional support to the Foundation will have been presented to the Executive Committee and the Board of Directors prior to the meeting of the House.

Cost Awareness Committee

Virgle McEver, M.D., Chairman

The Cost Awareness Committee held two meetings during the year. This report addresses three matters considered by the Committee.

Resolution on Cost of Medical Care

Resolution 10 from the 1983 House of Delegates was referred to the Cost Awareness Committee. The resolution proposed that MAG endorse a 10% across the board reduction in physician fees and challenge business and labor to cut their prices and wages. The Committee recommended that it would be impractical to endorse a 10% cut; rather, it proposed that MAG adopt a position urging physicians to "hold the line" on fees and where appropriate (as in areas of high unemployment) reduce fees. This recommendation was made to the Board of Directors in September. Acting on advice from MAG's legal counsel, the Board decided to take no action on the matter.

At its March Board meeting, the AMA acted favorably on a similar resolution, and urged all physicians to freeze fees for a one-year period. This action attracted national attention both to AMA's position and to the entire complex matter of health care costs. Several Georgia county medical societies took identical action after the AMA Board meeting. The MAG Executive Committee adopted the policy at its March 11 meeting.

Gathering Information on Local Health Care Cost Coalitions and Encouraging the Formation of Coalitions

The Committee attempted to gather information on local coalitions in a comprehensive and systematic way by means of a letter and questionnaire to each county medical society president. However, response was inadequate and phone calls were made to the larger county medical societies to ascertain the existence of local efforts in cost containment. The following summaries are based on the questionnaires (in the three cases for which the questionnaires were returned) and (in the other cases) on telephone interviews.

Albany

The Albany Task Force on Health was established in 1983 and is operational. Its membership includes the county medical society, hospitals, individual physicians, the Blues, commercial insurers, business, and the Chamber. It has no budget; the Chamber provides staff. The projects of the Task Force include access to care, alternate delivery systems, data collection.

Atlanta

The Greater Atlanta Coalition on Health Care was formed in 1982. Its members include business, health insurers, and health-related associations (Medical Association of Georgia and Medical Association of Atlanta are sustaining members). The coalition has a budget of $200,000 (including a $100,000 grant from the Robert Wood Johnson Foundation) and a staff of three. Its projects include utilization management, data collection on utilization, community education, and legislation.

Augusta

The Chamber of Commerce has formed a Committee on Alternative Forms of Health Care and Health Care Cost Containment. It held one well-attended meeting in October 1983, but no action has been taken since.

Cobb County

The Cobb County Coalition, formed under the Cobb Chamber, is in the developmental stage. Its membership includes the county medical society, hospitals, insurers, business, and the Chamber. It has no budget; its members donate staff. Its planned activities include projects in the areas of benefit design, member education, and employee disability/return to work. The Cobb Coalition will work in conjunction with the Atlanta Coalition.

Columbus

The Columbus Health Care Coalition, Inc. is composed of 51 employers, with 30,000 employees and 45,000 insured dependents. There are no physicians in the coalition; the three hospitals are members as employers. The first efforts of the coalition were in employer education and plan design. The coalition is now getting ready to establish several PPOs. The coalition will gather data on utilization, and plans in the future to initiate preadmission screening and concurrent review.

Dalton

The Dalton Chamber of Commerce has established a Cost Containment Committee. Two physicians serve on the Committee. The Committee has not yet been active, but is planning a seminar to build interest and to educate the public.

A private consulting firm in Dalton has as clients several of the area's large employers, and is working on benefits design, employee education, and utilization review.

Macon

The Macon Area Employers' Coalition on Health Care was formed approximately 18 months ago without physician or hospital involvement. The Coalition's main thrust is towards forming a PPO; it is also interested in preadmission certification, concurrent utilization review, and second opinions.

The Bibb County Medical Society has been invited to respond to the Coalition's plans, and will do so prior to the MAG Annual Session.

Savannah

The Savannah Business Group on Health Care Cost Management is composed of 10 of the larger employers in Savannah. The Group presently conducts concurrent review in two hospitals. Four companies are planning to add preadmission certification and second surgical opinions. The Georgia Medical Society has offered to form a peer review organization to conduct the program for the Business Group.

The Committee is also aware of efforts in Gainesville, Rome, Tifton, Athens, LaGrange, Thomasville, Cartersville, and Carrollton.

Committee Plans for FY84-85

The Committee's proposed budget includes funds to conduct seminars for physicians and businessmen in health care cost management. The purpose of the seminars will be to initiate interest in cooperative approaches to cost containment.

Supplemental Report
Cost Awareness Committee

Virgle McEver, M.D., Chairman

The following list contains key contacts for the identified coalitions in Georgia:

Georgia Health Care Cost Coalitions

Albany

Albany Task Force on Health
P.O. Box 308
Albany, GA 31702
(912) 883-6900
Contact: Lamar Clifton, Chamber of Commerce

Atlanta

Greater Atlanta Coalition on Health Care, Inc.
1300 North Omni International
Atlanta, GA 30330
(404) 521-0845
Contact: Walker McCune, Executive Director

Cobb County

Cobb County Coalition
c/o Cobb County Chamber of Commerce
820 Cobb Parkway, N.E.
Marietta, GA 30060
(404) 427-4227
Contact: Ken Kirk, Chamber of Commerce

Columbus

Columbus Health Care Coalition, Inc.
c/o A. S. Hansen, Inc.
P.O. Box 1995
Columbus, GA 31902
(404) 322-7548
Contact: Claude Kent

Dalton

Cost Containment Committee
Dalton Chamber of Commerce
P.O. Box 99
Dalton, GA 30720
(404) 278-7373
Contact: Charles Van Rysselberge, Executive Vice President

Macon

Macon Area Employers' Coalition on Health Care
c/o G. Paul Jones, Chairman
P.O. Box 6497
Macon, GA 31213
(912) 788-4641

Savannah

Savannah Business Group on Health Care Cost Management, Inc.
905 Abercorn
Savannah, GA 31401
(912) 232-3346
Contact: Lee Phillips, President

Rome

Industrial Council
Rome Area Chamber of Commerce
P.O. Box 406
Rome, GA 30161
(404) 291-7663
Contact: Bruce Schlosberg, Executive Vice President

LaGrange

LaGrange Area Health Care Coalition
c/o Roger Orange, Personnel Director
Haynes Hoisery
120 Cooley Industrial Way
LaGrange, GA 30240
(404) 884-2631

Thomasville

Ad Hoc Committee on Health Care Costs
Thomas Area County Medical Society
Contact: William Z. Bridges, M.D., President
Thomas Area County Medical Society
808 Gordon Avenue
Thomasville, GA 31792
(912) 226-9211

Gainesville

Robert H. Anderson, Jr., MD
Chairman, Cost Containment Committee
Hall County Medical Society
149 Gold Street
Gainesville, GA 30501
(404) 536-2323

Clifton McDuffie, Executive Vice President
Gainesville Chamber of Commerce
P.O. Box 374
Gainesville, GA 30503
(404) 532-6206

Physician Contacts for Coalitions

Albany

Charles D. Hollis, Jr., MD
1610 N. Valencia Drive
Albany, GA 31707
(912) 888-1898

Atlanta

H. Duane Blair, MD
755 Columbia Drive, Suite 919
Decatur, GA 30030
(404) 378-3514

Louis H. Felder, MD
35 Collier Road, N.W.
Atlanta, GA 30309
(404) 355-1757

Cobb County

Richard Cohen, MD
1620 Mulkey Road
Austell, GA 30001
(404) 941-7227

Columbus

Charles C. Stamey, MD
629-20th Street
Columbus, GA 31904
(404) 324-4891

John D. Watson, MD
P.O. Drawer 2787
Columbus, GA 31902
(404) 571-1050

Dalton

David Wells, MD
1219 Memorial Drive
Dalton, GA 30720
(404) 278-1696

Macon

Rodney Browne, MD
380 Hospital Drive
Macon, GA 31201
(912) 743-4646

Savannah

Dan H. Willoughby, MD
2 Midtown Medical Center
Savannah, GA 31401
(913) 232-4740

Rome

Joel Todino, MD
11 John Maddox Drive
Rome, GA 30161
(404) 295-3961

LaGrange

Joseph M. Almand, MD
606 South Greenwood Street
LaGrange, GA 30240
(404) 884-2686

A. Glenn Bailey, MD
303 Smith Street
LaGrange, GA 30240
(404) 882-8831

Robert B. Copeland, MD
1550 Doctors Drive, Suite 301
LaGrange, GA 30241
(404) 884-2641

Thomasville

William Z. Bridges, MD
808 Gordon Avenue
Thomasville, GA 31792
(912) 226-9211

Thomas F. Lear, Jr., MD
P.O. Box 1912
Thomasville, GA 31792
(912) 226-8670

Fred E. Murphy, MD
602 Victoria Pl.
Thomasville, GA 31792
(912) 226-2753

Impaired Physicians Committee

Edward J. Waits, M.D., Chairman

The Impaired Physicians Committee met four times during the past year. Our meetings were well attended by the old and new members of our committee with enthusiastic participation of all.

Our agendas included regular reports from Dr. G. Douglas Talbott, Medical Director of the Impaired Physicians Program of MAG and Dr. William Farley, Program Director of the Impaired Physicians Program of the Medical Association of Georgia.

Additional topics covered during our meetings are listed as follows:

1. Introduced during the year was the computer project of the Impaired Physicians Program, headed up by Drs. Carl Gallagos and Merrill Horton. These physicians are instituting a computerized program analysis of the previous nine years' experience with the Impaired Physicians Program including collecting data on over 700 physicians. This is a most exciting, challenging, and comprehensive study, which will produce some outstanding original articles in the field of research and treatment for addicted physicians and health professionals from our program. Drs. Gallagos and Horton have attended our last three meetings and continued to present their progress with this exciting program.
2. The separation of the Medical Association of Georgia from the MARR (Metro Atlanta Recovery Residencies) Program and affiliation with the newly formed CORR (Caduceus Outpatient Recovery Residencies) program.
3. CORR is currently operating twelve (12) half-way houses and four (4) three-quarter houses under the leadership of Mrs. Marge Farley, Program Manager for CORR.
4. This change included leaving the DeKalb Addiction Clinic for Phase II and affiliation with SAFE (Substance Abuse Free Existence) Outpatient Program for Phase II of our four (4) month program. This transition occurred in December of 1983, and has progressed smoothly since that time.
5. The problem of "counterfeit programs" attempting to treat impaired health professionals with the label of calling themselves equal or similar to the MAG Program were discussed in some detail. Our committee will continue to review any program for credentialing as a comparable one to the MAG program. The Committee feels that any physicians being treated elsewhere by comparable initial 30-day programs who desire advocacy of the Medical Association of Georgia should be triaged and evaluated by our Program prior to any granting of advocacy or follow-up after-care treatment.
6. The Advocacy Program of the Medical Association of Georgia's Impaired Physicians Program will begin with an all day Workshop to be held in conjunction with the meeting of the House of Delegates at the Ritz-Carlton Hotel on April 27, 1984.
7. The concept of the Hospital Based Wellness Program has also been reviewed by this Committee, and has been presented to the Medical Staff Section at the MAG Leadership Conference by your chairman, and will continue to be implemented through the Advocacy Program.
8. The Committee continues to review our program's role as a model for other state societies. The Georgia Dental Association, Georgia Nurses Association, and Georgia Pharmaceutical Association have set up programs patterned after MAG's. The MAG model has been presented to 37 state societies and four provinces in Canada.

Medical Aspects of Sports Committee

Letha Y. Hunter, M.D., Chairman

The Medical Aspects of Sports Committee decided to submit articles on sports medicine to be published in the *MAG Journal* as the Committee projects for 1983-84. We have been working with the editor on this and hope to have all the articles (list of titles and authors are listed below) published in the spring or summer of this year.

Although this somewhat strays from our basic charge (that is, the education of coaches and trainers) we felt through such a series of articles we could reach family and team physicians who are working with the high schools and caring for the athletes. The Committee hopes next year to publish a newsletter which we can distribute late in the summer to coaches and trainers for a more direct approach to education at this level. Funds for the newsletter have been included in the Committee's budget request for FY84-85.

"Organizing High School Preparticipation Screening Examination for Sports Participants"
Steve Hunter, M.D.

"Preventing, Recognizing, and Managing Heat Problems in Athletics"
William Strong, M.D.

"Food for Sport" (Includes pregame meal planning as well as programs for athletes to lose and gain weight sensibly)
William Mulherin, M.D.

"Drugs in Athletics"
David Watson, M.D.

"Emergency Room Treatment of Common Maxiofacial Sports Injuries"
Robert Crow, M.D.

"Athletics and the Reproductive Tract"
Joe Massey, M.D.

Nursing Committee

John P. Wilson, M.D., Chairman

The Nursing Committee has been active primarily in conjunction with the Georgia Nurses Association through the Joint Practice Commission to address the charge to the committee.

It has recommended the establishment of Joint Practice Committees in all institutions, and this was submitted to the Board of the Medical Association of Georgia. Definitive action was deferred on this proposal with the probability that the revised version will be submitted at a later date.

Further evaluation of the proposed Nurse Practice Act has been deferred awaiting the final form which the State Board of Nursing will submit to the legislature for introduction. The Nursing Committee is working with the Committee on Legislation in this regard.

Physician-Lawyer Liaison Committee

James A. Kaufmann, M.D., Chairman

The highlight of the year's activity of the Physician-Lawyer Liaison Committee was the Medical-Legal Issues Conference held in Atlanta in December. MAG Mutual provided financial support. One hundred seventeen MAG members attended the conference designed to help the physician cope with the growing legal aspects of the practice of medicine.

The major areas covered included competition in medicine, professional corporations, governmental regulation, diagnosis-related groups, and domestic relations. The faculty consisted of a distinguished panel of attorneys, including Attorney General Michael Bowers, MAG's and AMA's chief legal counsels, and others expert in various areas of the law.

The high attendance clearly indicated the keen interest of MAG members in this kind of conference. The attendees also gave the conference high marks. All those responding rated the program "excellent" or "good," and all recommended that MAG conduct similar programs in the future. In addition, the attendees suggested four additional topics for inclusion in the next program.

The Committee held an additional meeting during the year, at which the *Principles Governing Physician-Attorney Relationships* were discussed. MAG has been attempting for several years to revise the *Principles,* which has been in effect since 1969. MAG wishes to revise those portions of the *Principles* dealing with the release of patient information, advance payment of the physician's fee by the attorney, and other less important sections.

The State Bar of Georgia has been heretofore unwilling to make these changes; therefore, the Committee will continue efforts in this regard.

The Committee feels that it is vital to medicine to develop a better dialogue with the State Bar and the lawyers of Georgia. This is particularly cogent in the present professional liability crisis and other important legal developments.

Due to the high level of interest in the Medical-Legal Conference, the Committee plans another major conference in Atlanta in 1984-85, and additional, smaller conferences in different parts of the state (in cooperation with county medical societies). The Committee's budget request included funds for these events.

Prison Health Care Committee

Robert DeJarnette, Jr., M.D., Chairman

The Committee on Prison Health Care met four times during the fiscal year 1983-84. At last year's Annual Session, the Executive Committee appointed Robert DeJarnette, Jr., of Vidalia, to serve as Chairman, and he called the first meeting in June.

Funding for the activities of the Jail Health Care Program which is directed by this Committee, was obtained from the Georgia Department of Offender Rehabilitation (DOR) in the amount of $40,480 for the state's fiscal year beginning July 1, 1983, and ending June 30, 1984. This same amount has been included in the DOR budget for 1984-85 and has been approved in the most recent legislature. Considering no increase in funding for the next fiscal year, it is anticipated that accreditation fees collected will cover minimal increases.

At the Committee meeting in October, the Committee approved that a new position be added to the staff for this program for the purpose of assisting in increased accreditation activities. With the additional position it was also agreed that secretarial time should be increased from 25 to 50% for this program. However, the funding for the position is not currently available, and attempts will be made by the Committee to find the additional funding for the position.

Technical assistance was provided to many county jails during the year, and technical assistance was increased to the state prisons. As a result, a number of institutions have been accredited by the Committee. Some county jails

accredited by the Committee were Hall County in Gainesville, Forsyth County in Cumming, Monroe County in Forsyth, and Chatham County in Savannah. The Committee assisted in the accreditation of the Cobb County Jail. Prison facilities receiving accreditation during the year were: Montgomery C.I., in Mount Vernon, Rutledge C.I. in Columbus, Georgia Industrial Institute in Alto, Georgia State Prison in Reidsville, and Central Correctional Institute in Macon. Dodge Correctional Institute in Chester is awaiting a Committee decision. A number of site visits for accreditation are already scheduled to occur during March and early April. They are reaccreditation for the Forsyth County Jail in Cumming, Gordon County Jail in Calhoun, and Douglas County Jail in Douglasville.

Presently the accreditation program being offered by this Committee of the MAG is unique. Two states are attempting to follow our example, California and Colorado. The California program is ready for implementation in the next few months. Both of these state medical society staff persons have been in contact with MAG for information in setting up an accreditation program. The only other accreditations are available through national sources such as a newly established commission which developed from the former AMA program and through the American Correctional Association which is a total facility accreditation. Both of these accreditations are very costly for facilities. As a result, accreditation by our Committee remains a desirable and feasible recognition for quality medical care in correctional facilities in the State of Georgia.

A very successful Symposium For Correctional Health Care was presented by this Committee on November 19-20, 1983, at the Terrace Garden Inn in Atlanta. It was attended by more than 75 correctional health personnel with over thirty-five attendees being physicians who work in correctional institutions. Committee members and other invited guests made presentations specific to correctional medicine. Evaluations from attendees indicated that they found the experience valuable and unique. Many health personnel working in correctional institutions feel very isolated from their professions, having peer contact with only those who work in their facilities, and some work alone. Thus, our symposium provides an exceptional opportunity for communication among these professionals. Requests have been received to make the symposium an annual event rather than every two years as in the past.

Committee members remain very active in conducting the site visits as they are scheduled and in making community presentations to inform appropriate groups of the accreditation program and to make accreditation awards when called upon.

This Committee appreciates the valuable support given by other members of the MAG and respectfully submits this report as information on the progress and growth experienced during the past year.

Professional Liability Insurance Committee

Richard C. Mattison, M.D., Chairman

During 1983 and 1984 the Professional Liability Insurance Committee met on an irregular basis to respond to needs for information from the Executive Committee and upon request from the carriers to discuss rate increases.

The initial meeting was designed to gather information regarding the malpractice liability exposure which may be incurred by members of the Medical Association of Georgia joining PPOs or other contractual health maintenance organizations. It was determined jointly with the legal counsel and the management of both MAG Mutual and St. Paul Insurance Companies that the risk is present; however, at present it is not determinable. There will be no anticipated surcharge for members of our society joining PPOs, HMOs, or other health care organizations on a contractual basis.

The Malpractice Liaison Committee met again on October 1, 1983, to discuss the changes in the St. Paul Insurance Company rate increase. These are submitted as a report from the committee of October 1, 1983.

The last issue which was addressed by the Malpractice Liaison Committee, which may justify its continuance, was that issue which may be a potential problem in the future. As there are now two major carriers in the state, the records of members covered by one or the other are no longer disclosed to the Medical Association of Georgia. The potential problem arises if a practitioner in the state, failing to get malpractice coverage from either institution, may elect to practice without malpractice coverage. Currently, it is thought that there is less than 3% of the practitioners in Georgia falling into this category. The Commissioner of Insurance was contacted and felt that there were no provisions in the state code to allow for monitoring of this potential problem. It was therefore suggested by the committee and approved by the Executive Committee to maintain close ties to the Georgia Hospital Association so that any person known by the organization not to have malpractice coverage be identified. The information might, on a confidential basis, be made available to the MAG.

It is my judgment that there is some justification for the continuance of the committee, although the two carriers' dominance in this state diminishes the need for time and money expended by the MAG to enhance activities of this committee.

Public Health Committee

O. Grey Rawls, M.D., Chairman

The Public Health Committee received information from the Department of Human Resources regarding the Community Care for the Elderly Act which is to be implemented in July, 1984. This will provide for an alternative to the nursing home for older people. Therefore, it is information which must be available to the medical community. Dr. Ben Okel presented this to the Executive Committee and is to prepare an article for the *MAG Journal*.

Other items from the DHR were discussed. MAG was requested to support a recommendation for additional funding for hypertension, diabetic control, and family planning. Without more adequate funds, these important services could not be maintained at their present level.

Methods of improving liaison with DHR were discussed and every effort will be made to accomplish this.

The Committee would like to become more active in providing information of broad interest to the public and if possible work in conjunction with other committees.

Before prescribing, see complete prescribing information in SK&F CO. literature or *PDR*. The following is a brief summary.

WARNING
This drug is not indicated for initial therapy of edema or hypertension. Edema or hypertension requires therapy titrated to the individual. If this combination represents the dosage so determined, its use may be more convenient in patient management. Treatment of hypertension and edema is not static, but must be reevaluated as conditions in each patient warrant.

Contraindications: Concomitant use with other potassium-sparing agents such as spironolactone or amiloride. Further use in anuria, progressive renal or hepatic dysfunction, hyperkalemia. Pre-existing elevated serum potassium. Hypersensitivity to either component or other sulfonamide-derived drugs.

Warnings: Do not use potassium supplements, dietary or otherwise, unless hypokalemia develops or dietary intake of potassium is markedly impaired. If supplementary potassium is needed, potassium tablets should not be used. Hyperkalemia can occur, and has been associated with cardiac irregularities. It is more likely in the severely ill, with urine volume less than one liter/day, the elderly and diabetics with suspected or confirmed renal insufficiency. Periodically, serum K^+ levels should be determined. If hyperkalemia develops, substitute a thiazide alone, restrict K^+ intake. **Associated widened QRS complex or arrhythmia requires prompt additional therapy.** Thiazides cross the placental barrier and appear in cord blood. Use in pregnancy requires weighing anticipated benefits against possible hazards, including fetal or neonatal jaundice, thrombocytopenia, other adverse reactions seen in adults. Thiazides appear and triamterene may appear in breast milk. If their use is essential, the patient should stop nursing. Adequate information on use in children is not available. Sensitivity reactions may occur in patients with or without a history of allergy or bronchial asthma. Possible exacerbation or activation of systemic lupus erythematosus has been reported with thiazide diuretics.

Precautions: Do periodic serum electrolyte determinations (particularly important in patients vomiting excessively or receiving parenteral fluids, and during concurrent use with amphotericin B or corticosteroids or corticotropin [ACTH]). Periodic BUN and serum creatinine determinations should be made, especially in the elderly, diabetics or those with suspected or confirmed renal insufficiency. Cumulative effects of the drug may develop in patients with impaired renal function. Thiazides should be used with caution in patients with impaired hepatic function. They can precipitate coma in patients with severe liver disease. Observe regularly for possible blood dyscrasias, liver damage, other idiosyncratic reactions. Blood dyscrasias have been reported in patients receiving triamterene, and leukopenia, thrombocytopenia, agranulocytosis, and aplastic and hemolytic anemia have been reported with thiazides. Thiazides may cause manifestation of latent diabetes mellitus. The effects of oral anticoagulants may be decreased when used concurrently with hydrochlorothiazide; dosage adjustments may be necessary. Clinically insignificant reductions in arterial responsiveness to norepinephrine have been reported. Thiazides have also been shown to increase the paralyzing effect of nondepolarizing muscle relaxants such as tubocurarine. Triamterene is a weak folic acid antagonist. Do periodic blood studies in cirrhotics with splenomegaly. Antihypertensive effects may be enhanced in post-sympathectomy patients. Use cautiously in surgical patients. Triamterene has been found in renal stones in association with the other usual calculus components. Therefore, 'Dyazide' should be used with caution in patients with histories of stone formation. A few occurrences of acute renal failure have been reported in patients on 'Dyazide' when treated with indomethacin. Therefore, caution is advised in administering nonsteroidal anti-inflammatory agents with 'Dyazide'. The following may occur: transient elevated BUN or creatinine or both, hyperglycemia and glycosuria (diabetic insulin requirements may be altered), hyperuricemia and gout, digitalis intoxication (in hypokalemia), decreasing alkali reserve with possible metabolic acidosis. 'Dyazide' interferes with fluorescent measurement of quinidine. Hypokalemia is uncommon with 'Dyazide', but should it develop, corrective measures should be taken such as potassium supplementation or increased dietary intake of potassium-rich foods. Corrective measures should be instituted cautiously and serum potassium levels determined. Discontinue corrective measures and 'Dyazide' should laboratory values reveal elevated serum potassium. Chloride deficit may occur as well as dilutional hyponatremia. Concurrent use with chlorpropamide may increase the risk of severe hyponatremia. Serum PBI levels may decrease without signs of thyroid disturbance. Calcium excretion is decreased by thiazides. 'Dyazide' should be withdrawn before conducting tests for parathyroid function.

Thiazides may add to or potentiate the action of other antihypertensive drugs.

Diuretics reduce renal clearance of lithium and increase the risk of lithium toxicity.

Adverse Reactions: Muscle cramps, weakness, dizziness, headache, dry mouth; anaphylaxis, rash, urticaria, photosensitivity, purpura, other dermatological conditions; nausea and vomiting, diarrhea, constipation, other gastrointestinal disturbances; postural hypotension (may be aggravated by alcohol, barbiturates, or narcotics). Necrotizing vasculitis, paresthesias, icterus, pancreatitis, xanthopsia and respiratory distress including pneumonitis and pulmonary edema, transient blurred vision, sialadenitis, and vertigo have occurred with thiazides alone. Triamterene has been found in renal stones in association with other usual calculus components. Rare incidents of acute interstitial nephritis have been reported. Impotence has been reported in a few patients on 'Dyazide', although a causal relationship has not been established.

Supplied: 'Dyazide' is supplied in bottles of 1000 capsules; Single Unit Packages (unit-dose) of 100 (intended for institutional use only); in Patient-Pak™ unit-of-use bottles of 100.

In Hypertension*... When You Need to Conserve K^+

Remember the Unique Red and White Capsule: Your Assurance of SK&F Quality

Serum K^+ and BUN should be checked periodically (see Warnings and Precautions).



Potassium-Sparing

DYAZIDE®

Each capsule contains 50 mg. of Dyrenium® (brand of triamterene) and 25 mg. of hydrochlorothiazide.

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The unique red and white Dyazide® capsule: Your assurance of SK&F quality.



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J-4044 January 1984



(L to R) Drs. James A. Kaufmann, Vice Speaker, and Jack F. Menendez, Speaker of the House.

Second Session — House of Delegates

Saturday, April 28, 1984

The Second Session of the MAG House of Delegates was called to order at 9:00 AM, Saturday, April 28, 1984, in Salons 1 and 2, Ritz-Carlton Hotel, Buckhead, by Speaker Jack F. Menendez, MD.

Dr. Menendez requested that Certificates of Appreciation be presented to three state legislators who have been strong advocates of quality medical legislation. These were presented to: Senator Roy Barnes by Dr. James Kaufmann; Representative Bobby Parham by Dr. William Headley; and Representative Tommy Chambless by Dr. Frank Middleton.

William W. Moore, Jr., MAG President, introduced Joseph F. Boyle, MD, AMA President-Elect, for an address to the House of Delegates.

Following Dr. Boyle's address, the Speaker called for a report from the Credentials Committee which was given by Milton I. Johnson, Macon. Dr. Johnson reported 184 Delegates were present, representing 42 county medical societies. As provided in Chapter III, Section 3 of the Bylaws, a quorum was present.

Election

Ballots for the contested seat for the Officer of Treasurer were distributed by the Tellers. Candidates included Charles R. Underwood, Marietta, and Cyler D. Garner, Gordon.

Reference Committee Reports

Speaker Menendez called for reports from the Reference Committee Chairmen.

Announcement of Election Reports

The Speaker announced the election of Cyler D. Garner as Treasurer. The results of the 1984 elections are as follows:

President-Elect — William D. Logan, Jr., Atlanta
Second Vice President — Joseph P. Bailey, Augusta
Secretary — John T. Yauger, Atlanta
Treasurer — Cyler D. Garner, Gordon
AMA Delegate — Carson B. Burgstiner, Savannah
AMA Delegate — H. Hilt Hammett, Jr., LaGrange
AMA Delegate — Charles D. Hollis, Jr., Albany
AMA Delegate — J. Dan Bateman, Albany
AMA Alternate Delegate — Joe C. Stubbs
AMA Alternate Delegate — S. William Clark, Jr., Waycross
AMA Alternate Delegate — L. Newton Turk, III, Atlanta
AMA Alternate Delegate — James H. Sullivan, Columbus
AMA Alternate Delegate — C. Peter Lampros, Toccoa
AMA Alternate Delegate — Virgie W. McEver, Warner Robins

New Business

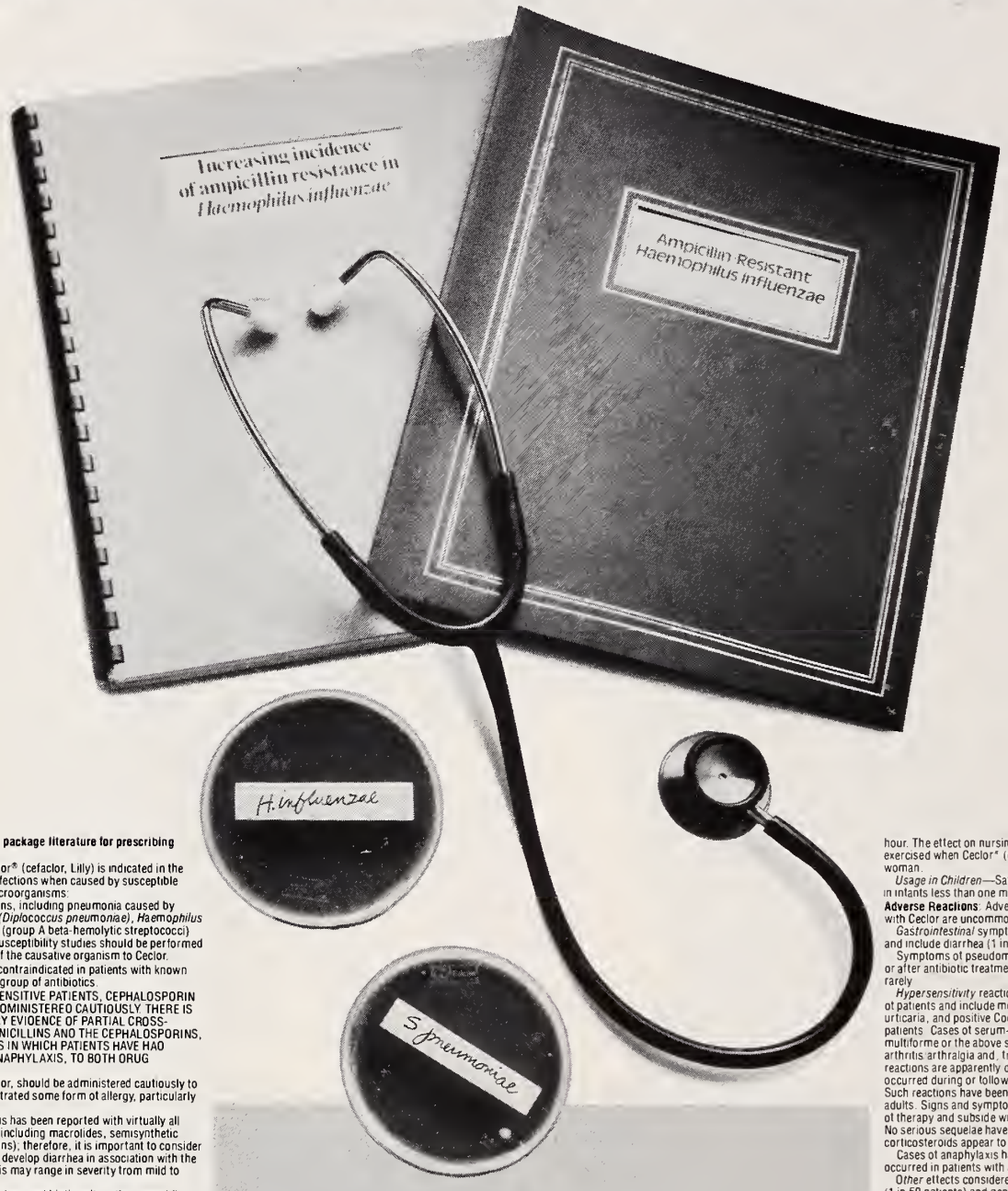
Under motion by delegate Ralph Tillman, the House expressed its pride in and congratulations to Luella M. Klein, MD, as the first representative from Georgia and the first woman ever to serve as President of the American College of Obstetrics and Gynecology.

By acclamation, the House extended its appreciation to Speaker Menendez and Vice Speaker Kaufmann for their expertise in presiding over the activities of the MAG House of Delegates and to the MAG staff for its efficiency in coordinating all the functions required for a successful meeting.

Adjournment

There being no further business before the House of Delegates, the Speaker adjourned the 1984 House of Delegates at 4:45 PM.

An added complication... in the treatment of bacterial bronchitis*



Some ampicillin-resistant strains of Haemophilus influenzae—a recognized complication of bacterial bronchitis*—are sensitive to treatment with Ceclor.[1-6]

In clinical trials, patients with bacterial bronchitis due to susceptible strains of Streptococcus pneumoniae, H. influenzae, S. pyogenes (group A beta-hemolytic streptococci), or multiple organisms achieved a satisfactory clinical response with Ceclor.[7]

Ceclor®
cefaclor

Pulvules®, 250 and 500 mg

Brief Summary. Consult the package literature for prescribing information.

Indications and Usage: Ceclor® (cefaclor, Lilly) is indicated in the treatment of the following infections when caused by susceptible strains of the designated microorganisms:

Lower respiratory infections, including pneumonia caused by *Streptococcus pneumoniae (Diplococcus pneumoniae), Haemophilus influenzae,* and *S. pyogenes* (group A beta-hemolytic streptococci)

Appropriate culture and susceptibility studies should be performed to determine susceptibility of the causative organism to Ceclor.

Contraindication: Ceclor is contraindicated in patients with known allergy to the cephalosporin group of antibiotics.

Warnings: IN PENICILLIN-SENSITIVE PATIENTS, CEPHALOSPORIN ANTIBIOTICS SHOULD BE ADMINISTERED CAUTIOUSLY. THERE IS CLINICAL AND LABORATORY EVIDENCE OF PARTIAL CROSS-ALLERGENICITY OF THE PENICILLINS AND THE CEPHALOSPORINS, AND THERE ARE INSTANCES IN WHICH PATIENTS HAVE HAD REACTIONS, INCLUDING ANAPHYLAXIS, TO BOTH DRUG CLASSES.

Antibiotics, including Ceclor, should be administered cautiously to any patient who has demonstrated some form of allergy, particularly to drugs.

Pseudomembranous colitis has been reported with virtually all broad-spectrum antibiotics (including macrolides, semisynthetic penicillins, and cephalosporins); therefore, it is important to consider its diagnosis in patients who develop diarrhea in association with the use of antibiotics. Such colitis may range in severity from mild to life-threatening.

Treatment with broad-spectrum antibiotics alters the normal flora of the colon and may permit overgrowth of clostridia. Studies indicate that a toxin produced by *Clostridium difficile* is one primary cause of antibiotic-associated colitis.

Mild cases of pseudomembranous colitis usually respond to drug discontinuance alone. In moderate to severe cases, management should include sigmoidoscopy, appropriate bacteriologic studies, and fluid, electrolyte, and protein supplementation. When the colitis does not improve after the drug has been discontinued, or when it is severe, oral vancomycin is the drug of choice for antibiotic-associated pseudomembranous colitis produced by *C. difficile*. Other causes of colitis should be ruled out.

Precautions: *General Precautions*—If an allergic reaction to Ceclor occurs, the drug should be discontinued, and, if necessary, the patient should be treated with appropriate agents, e.g., pressor amines, antihistamines, or corticosteroids.

Prolonged use of Ceclor may result in the overgrowth of nonsusceptible organisms. Careful observation of the patient is essential. If superinfection occurs during therapy, appropriate measures should be taken.

Positive direct Coombs' tests have been reported during treatment with the cephalosporin antibiotics. In hematologic studies or in transfusion cross-matching procedures when antiglobulin tests are performed on the minor side or in Coombs' testing of newborns whose mothers have received cephalosporin antibiotics before parturition, it should be recognized that a positive Coombs' test may be due to the drug.

Ceclor should be administered with caution in the presence of markedly impaired renal function. Under such conditions, careful clinical observation and laboratory studies should be made because safe dosage may be lower than that usually recommended.

As a result of administration of Ceclor, a false-positive reaction for glucose in the urine may occur. This has been observed with Benedict's and Fehling's solutions and also with Clinitest® tablets but not with Tes-Tape® (Glucose Enzymatic Test Strip, USP, Lilly).

Broad-spectrum antibiotics should be prescribed with caution in individuals with a history of gastrointestinal disease, particularly colitis.

Usage in Pregnancy—Pregnancy Category B—Reproduction studies have been performed in mice and rats at doses up to 12 times the human dose and in ferrets given three times the maximum human dose and have revealed no evidence of impaired fertility or harm to the fetus due to Ceclor. There are, however, no adequate and well-controlled studies in pregnant women. Because animal reproduction studies are not always predictive of human response, this drug should be used during pregnancy only if clearly needed.

Nursing Mothers—Small amounts of Ceclor have been detected in mother's milk following administration of single 500-mg doses. Average levels were 0.18, 0.20, 0.21, and 0.16 mcg/ml at two, three, four, and five hours respectively. Trace amounts were detected at one hour. The effect on nursing infants is not known. Caution should be exercised when Ceclor* (cefaclor, Lilly) is administered to a nursing woman.

Usage in Children—Safety and effectiveness of this product for use in infants less than one month of age have not been established.

Adverse Reactions: Adverse effects considered related to therapy with Ceclor are uncommon and are listed below.

Gastrointestinal symptoms occur in about 2.5 percent of patients and include diarrhea (1 in 70).

Symptoms of pseudomembranous colitis may appear either during or after antibiotic treatment. Nausea and vomiting have been reported rarely.

Hypersensitivity reactions have been reported in about 1.5 percent of patients and include morbilliform eruptions (1 in 100). Pruritus, urticaria, and positive Coombs' tests each occur in less than 1 in 200 patients. Cases of serum-sickness-like reactions (erythema multiforme or the above skin manifestations accompanied by arthritis/arthralgia and, frequently, fever) have been reported. These reactions are apparently due to hypersensitivity and have usually occurred during or following a second course of therapy with Ceclor. Such reactions have been reported more frequently in children than in adults. Signs and symptoms usually occur a few days after initiation of therapy and subside within a few days after cessation of therapy. No serious sequelae have been reported. Antihistamines and corticosteroids appear to enhance resolution of the syndrome.

Cases of anaphylaxis have been reported, half of which have occurred in patients with a history of penicillin allergy.

Other effects considered related to therapy included eosinophilia (1 in 50 patients) and genital pruritus or vaginitis (less than 1 in 100 patients).

Causal Relationship Uncertain—Transitory abnormalities in clinical laboratory test results have been reported. Although they were of uncertain etiology, they are listed below to serve as alerting information for the physician.

Hepatic—Slight elevations of SGOT, SGPT, or alkaline phosphatase values (1 in 40).

Hematopoietic—Transient fluctuations in leukocyte count, predominantly lymphocytosis occurring in infants and young children (1 in 40).

Renal—Slight elevations in BUN or serum creatinine (less than 1 in 500) or abnormal urinalysis (less than 1 in 200).

[061782R]

*Many authorities attribute acute infectious exacerbation of chronic bronchitis to either *S. pneumoniae* or *H. influenzae*.[8]

Note: Ceclor is contraindicated in patients with known allergy to the cephalosporins and should be given cautiously to penicillin-allergic patients.

Penicillin is the usual drug of choice in the treatment and prevention of streptococcal infections, including the prophylaxis of rheumatic fever. See prescribing information.

References

1. Antimicrob. Agents Chemother., *8*:91, 1975.
2. Antimicrob. Agents Chemother., *11*:470, 1977.
3. Antimicrob. Agents Chemother., *13*:584, 1978.
4. Antimicrob. Agents Chemother., *12*:490, 1977.
5. Current Chemotherapy (edited by W. Siegenthaler and R. Luthy), II:880. Washington, D.C.: American Society for Microbiology, 1978.
6. Antimicrob. Agents Chemother., *13*:861, 1978.
7. Data on file, Eli Lilly and Company.
8. Principles and Practice of Infectious Diseases (edited by G.L. Mandell, R.G. Douglas, Jr., and J.E. Bennett), p. 487. New York, John Wiley & Sons, 1979.

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Additional information available to the profession on request from Eli Lilly and Company, Indianapolis, Indiana 46285.

Eli Lilly Industries, Inc.
Carolina, Puerto Rico 00630

300035

Report of Reference Committee A

E. M. Molnar, M.D., Columbus, Chairman
Stephen Boyle, M.D., Conyers, Vice Chairman

In addition to the Chairman and Vice Chairman named above, the following persons served on Reference Committee A: Carl V. Hancock, Jr., MD, Albany; J. Moultrie Lee, MD, Savannah; Rodney M. Browne, MD, Macon; Joe B. Massey, MD, Atlanta; and Harry Porter, MD, Marietta.



E. M. Molnar, M.D., Columbus, served as Chairman of Reference Committee A.

Access to Health Care Committee

M. Julian Duttera, Jr., M.D., Chairman

In the past year, the Access to Health Care Committee has continued to oversee MAG's programs relating to the recruitment and retention of physicians in those areas of Georgia with a demonstrated need. Each of these programs is discussed separately.

Medical Fair and Pre-Practice Seminar

The function of the Medical Fair, held by MAG and other sponsors since 1977, is to create an opportunity for residents and Georgia communities to meet and discuss practice opportunities.

The 1983 Medical Fair was held in Augusta on October 14-16. One hundred sixteen residents attended, representing 13 specialties. Representatives of 38 Georgia communities exhibited at the 1983 Fair.

The Medical Fair is a well-established event, with eight public and private organizations contributing staff time and/or funds to sponsor the Fair each fall. MAG's contribution consists of 1/10 of a professional's time and 1/20 of a secretary's time, plus a $2,000 donation to sponsor a reception. MAG also makes its computer capabilities available at a nominal charge to process the residents' resumés which are used at the Fair.

Computer Physician Placement Service

Pursuant to the direction of the 1983 House of Delegates, the Committee has expanded and improved the Physician Placement Service.

This service consists of two lists — a list of physicians interested in practicing in Georgia and a list of practice opportunities. Each list is now updated and distributed monthly to the subscribers. A $10 semi-annual fee is charged to non-MAG members. Twice a year, in April and October, out-of-date entries are dropped, and new master lists are printed.

The present lists (February) contain 86 physicians in 25 specialties and 105 communities seeking physicians in 17 specialties. Income since the fiscal year began has totaled $2,200 (through February). The cost of operating the program has totaled $2,194.00 (through February). (This does not include staff time except for some part-time secretarial help which was paid with part of the program's income from fees.)

Appalachian Regional Commission Contract

The ARC Physician Recruitment Program of the Medical Association of Georgia was initiated on September 15, 1983, when a contract was signed between MAG and the Appalachian Regional Commission. To implement the conditions of the contract, an independent contractor was retained on September 27, 1983.

A first step in the implementation process was the creation of a Program Plan to guide the project through the first year of funding. The Program Plan was approved by the Access to Health Care Committee on October 15, 1983, and by the MAG Executive Committee on October 27, 1983.

Since the approval of the plan, these activities have taken place:

1) Extensive interviews have been conducted with physicians, hospital administrators, and community leaders throughout the 35 Appalachian counties targeted by the project,
2) Local medical society members have been involved in such activities as an economic development planning retreat in Polk County, the diagnosis of a physician retention problem in Dade County, the planning of a conference on physician recruitment in Rome (June 7), recruitment activities in 9 counties, and a resolution of support for MAG's efforts by the Habersham County Medical Society on December 13, 1983,
3) A Physician Placement Interest Group has been formed to provide continuing educational activities for staff involved in physician placement activities and to encourage coordination of activities, and
4) The Appalachian Regional Commission has offered a second year of funding.

The Access to Health Care Committee will meet to discuss plans for the future and to make recommendations for the Executive Committee.

Recommendations

(1) That MAG continue to support the Medical Fair and Pre-Practice Seminar in 1984 in sponsorship and financial commitment.

(2) That MAG continue its computer Physician Placement Service with the improvements made in FY 83.
(3) That MAG seek a second year of funding from the Appalachian Regional Commission and seek additional funds from private philanthropic foundations in order to continue the Physician Recruitment Program and expand it to cover the entire state.

Fiscal Note

Funds for recommendations 1 and 2 are in the Committee's FY 1984-1985 budget request. Funds for recommendation 3 will come entirely from outside sources.

House Action

Adopted.

Maternal & Infant Health Committee

Luella M. Klein, M.D., Chairman

In response to a report from Dr. Klein, Chairman of the MAG Maternal & Infant Health Committee, the MAG Executive Committee recognized the need to address the problems associated with Georgia's infant mortality rate. The Executive Committee asked Dr. Klein to establish a task force consisting of members of the MAG Maternal & Infant Health Committee; representatives of the specialties of OB/GYN, pediatrics, and family physicians; appropriate agencies, e.g., Georgia State Medical Association, Georgia Hospital Association, DHR, DMA, M & I Council, etc.; and others as deemed advisable, to formulate plans for improvement in this area. This report is primarily devoted to the activities of this task force.

From the initial meeting, the following lists of problems and suggestions for resolution were derived:

Problems Associated With Infant Mortality

Access/Availability of prenatal, delivery, newborn, and infant care

The committee recognized that there are some counties which do not need or could not support obstetrical care within its geographic boundaries, but still felt these are problem areas:

- Number of counties without physicians who provide obstetrical care.
- Number of counties without hospitals which provide obstetrical care.
- Number of counties without public health prenatal care.
- Lack of private physician backup for public health clinics.
- Patient transportation problems.

Funding

- Physicians and hospitals that do not accept indigent patients.
- Physicians who do not accept Medicaid.
- On the other hand, physicians and hospitals that do accept indigent or Medicaid patients get them all and soon reach the point where they cannot accept more and stay in business.
- Lack of referral or funding across county lines for high risk or indigent patients.
- No consistency in the implementation or funding of the Georgia Hospital Care for the Medically Indigent Act.
- Inadequate funding for Public Health nurses, family planning, private care; high risk patients; Level II facilities; and Medicaid.
- Cost shifting created by all facilities and payers in their efforts to reduce their expenses.
- Lack of patient knowledge about cost of medical care.

Education/Motivation

- Lack of knowledge about and motivation to use family planning.
- Patients who do not take advantage of prenatal services that are available and show up as an emergency or walk-in at a hospital for delivery.
- Patient noncompliance with medical care regime and/or other actions which indicate the patient is not accepting responsibility for herself and the baby.

There were a number of "solutions" suggested but all those present agreed that the following activities should be pursued immediately:

- Urge all counties and state to implement and fund Care for the Indigent Act.
- Urge state funding of the DMA's proposal to expand coverage for the medically needy.
- The committee also urges all involved to place 1) the prevention of all but wanted pregnancies and 2) getting women into prenatal care at two months as their highest priority.
- Investigate what's working in other areas, both those counties in Georgia that have effective programs and what other states may be doing.
- Statewide and local cooperation between the public and private sectors in providing obstetrical care and infant follow-up care.

At its September meeting, the MAG Executive Committee voted to urge funding (1) across county lines for medical care for the indigent; (2) for the Department of Medical Assistance (Medicaid) proposal to expand benefits to coverage for the medically needy, including maternal and infant care for needy intact families; and (3) additional funding for public health services including the high-risk programs and local prenatal and family planning programs.

At its next meeting the basic premise throughout the task force discussion was that the infant mortality rate in Georgia is not only an issue that demands immediate attention, but is also a symptom of long-term problems involving us all — health, education, financial welfare, food, housing, transportation, expenditures of tax funds for each of these; and the current mores of our society.

Deliberation centered around two concerns:

1) That implementation of all the specific proposals discussed previously probably would not appreciably reduce the infant mortality statistics — that significant improvement is going to require cultural changes, and,
2) A physician practicing in a rural area, expressed the frustrations felt by all — we've identified these problems; what do we do about them?

Cultural Issues Identified

A. Education: The existence and/or uniformity of family life education in Georgia schools hinges on decisions made by local school boards which may be reluctant

or lack the resources to meet the need. State law is permissive rather than mandatory as to whether family life education is provided.

B. Mores/Public Opinion: Whether it is the result of the need for mores to change or the fact that they have — one consensus emerged. There is something wrong in a society in which public media implies in its programs and advertisements that "instant intimacy" is desirable and yet it can't, or won't, state that pregnancy should not, does not have to, or even can be the result. Advertisements, usually sexually suggestive, may be presented for a number of products that are offensive to a lot of people, but advertisements for contraceptives are not acceptable.

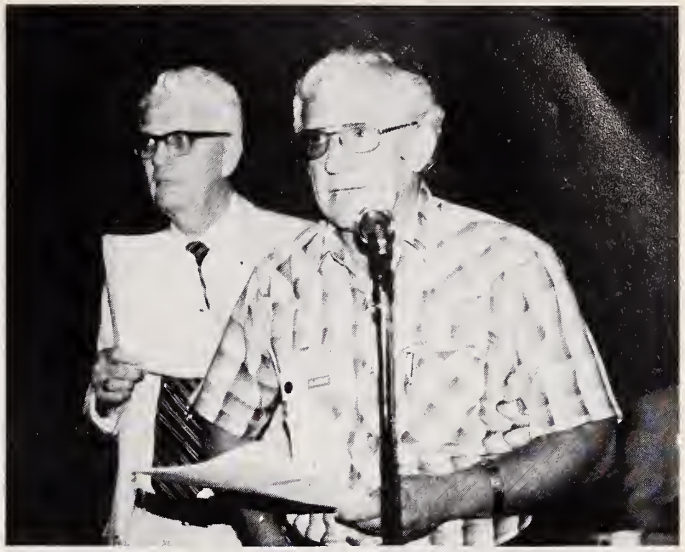
Specific Actions

A. Contact the Advertising Council about the possibility of developing public awareness campaign;
B. Find or help create local organizations that will study and help to resolve local problems — involve public and private health providers, governmental officials, volunteer organizations such as the auxiliaries of the county medical societies, March of Dimes, Jaycettes, etc.;
C. Use this task force (M&I) with representation from other appropriate organizations or agencies to address the statewide aspects such as research, legislation, interagency coordination and cooperation;
D. Develop mechanisms to target specific issues, within limited time frames, with the idea that these mechanisms would be left in place for ongoing action. These may vary in accordance with local needs and resources.

Suggestions for specific targets included: teenage pregnancy prevention; setting specific goals to reduce all indices of infant mortality by concerted action of all involved; reduce number of low birth weight infants; early enrollment of pregnant women in prenatal programs; establish referral and community outreach programs for Medicaid, indigent, high-risk mothers and infants, and public health patients; EDUCATE young people and the general public.

- Identify or develop incentives to increase physician participation in Medicaid;
- Investigate the possibility of legislation to limit physician liability when helping patients in need;
- Attempt to get the state criteria for eligibility for Aid for Dependent Children changed to a system based on family income. The current requirement that women be single parents before than can receive aid, with that aid directly tied to the number of children, appears to encourage pregnancies in the very population that has the highest infant mortality rate. Incentives would more appropriately be based on ways to decrease pregnancies.

Based in part on recommendations of this task force, limited funds have been included in the state budget to include increase payments for office visits and obstetrical care; aid for expansion of Medicaid benefits to the "medically needy" (very stringent application). A bill did pass the Georgia General Assembly requiring that any hospital which normally provides obstetrical care must provide care to a pregnant woman in labor regardless of her ability to pay, her assignment status, or county of residence. This law also requires that physicians and hospitals are to be reimbursed by the county of residence for "emergency" obstetrical services rendered to a non-resident indigent pregnant woman. It also protects physicians, nurses, medical assistants, hospitals, and their agents from malpractice unless they are grossly negligent.



(L to R) Drs. Milton Johnson, Macon, and Bruce Newsom, Columbus, state their views to the House.

The Atlanta Advertising Council did not accept the MAG proposals, but the M&I Task Force is in the process of implementing an awareness campaign to emphasize the extent of the problem of infant mortality in Georgia; a voluntary provider referral program; programs aimed at getting teenagers involved in discussing causes and ways to prevent teenage pregnancies; and identifying specific local community needs and help in the coordination of the public and private sector to address these needs.

Other Maternal and Infant Mortality Activities:

The Committee is still reviewing maternal deaths and is considering the possibility of developing a system to review infant deaths through the first year of life.

House Action

The House filed with commendation the report.

The House adopted a recommendation made by Reference Committee A which read:

"The MAG Maternal & Infant Task Force be encouraged to bring specific recommendations to the MAG Board of Directors to address the issues of high infant mortality, teenage pregnancy, and the high rate of premature births for possible solutions."

Membership Insurance Committee

Kenneth L. Goldman, M.D., Chairman

The Membership Insurance Committee has met several times during the past year and has considered several proposals presented to it. During its sessions, the Committee heard proposals for endorsement by the MAG from the National Life of Vermont Insurance Company regarding disability insurance. The Committee members, Kenneth L. Goldman, MD, Chairman; John T. Mauldin, MD,



Delegates to the 1984 House of Delegates shown here include Drs. Hilt Hammett, John Heard, Julian Duttera, Rhodes Haverty, Tom Johnson, James Skinner, Fleming Jolley, Alvin Clair, Hugo Moreno, and Norman Gardner.

William L. Amos, MD, William R. Hardcastle, MD, Roland S. Summers, MD, Walter E. Erhart, MD, and Mrs. Charles Underwood, Auxiliary Representative, have agreed that exclusive endorsement of any insurance product may well be counterproductive as regards MAG membership. It voted to consider each proposed program that is presented to it now and in the future on an individual basis. Therefore, the following recommendations are submitted:

Recommendations

1. That exclusive endorsements not be encouraged.
2. The National Life of Vermont Program be endorsed by MAG as presented.
3. Continue the endorsement of the SMA Insurance Program.
4. Continue the pre-existing Insurance Specialists, Inc. endorsement.

House Action

Adopted.

Committee on Physician's Assistants

Richard W. Cohen, M.D., Chairman

Last year this Committee was directed by the House of Delegates to cooperate with the Composite State Board of Medical Examiners in seeking legislative authority for the Composite State Board to administer an appropriate examination for the certification of physician's assistants in Georgia.

We accordingly met with the representative of the Composite Board and with officers of the Georgia Association of Physician's Assistants. We agreed that the MAG and GAPA would cosponsor the bill. The MAG legislative staff drafted it and saw that it was introduced in the last General Assembly.

I am pleased to say that we succeeded; HB 1027 passed, and the Governor signed it. As a result, starting on September 5, 1985, all persons desiring to become a certified PA in Georgia must pass an approved test as a prerequisite to certification.

Having completed this task, we find ourselves without new initiatives to pursue. We believe, however, that the MAG will benefit considerably from further examination of the role of the physician's assistant *relative to* that of the nurse practitioner. Our current charge prohibits this enlarged focus of activities, so we recommend that this Committee be disbanded in favor of the creation of a new MAG Committee on Non-Physician Health Care Providers.

As chairman I wish to thank the members of this Committee for their support and involvement:

Louis G. Cacchioli, MD, Hartwell
Leon Curry, MD, Metter
Paul E. Fitzpatrick, MD, Morrow
William W. Rawls, MD, Decatur
Thomas L. Tidmore, Jr., MD, Atlanta
John P. Wilson, MD, Atlanta
Mrs. Myron Katz (Auxiliary), Atlanta
Ray E. Ball, PA-C, GAPA Liaison, Columbus

Recommendation

That the MAG dissolve its Committee on Physician's Assistants and direct that further examination of PA-related issues be conducted by a new MAG Committee on Non-Physician Health Care Providers.

House Action

Adopted.

Public Relations Committee

Charles W. McDowell, Jr., M.D.

Your Public Relations (PR) Committee met twice in 1983-84 to plan and carry out its objectives. The PR Committee is charged to "provide advice, assistance, and coordination for all committees on communications with the membership and the public."

Last year the PR Committee made three recommendations to the House. The first was that MAG establish, effective June 1, a PR Department within the MAG. That was done.

The second recommendation was that an additional MAG staff person be employed to work exclusively in the area of public relations. The House approved an amended recommendation to employ or assign a person to work in PR. On December 5, Ms. Sherry Waronker was employed. Sherry is a graduate of the University of North Carolina at Chapel Hill and came to MAG from the PR firm of Ogilvy & Mather in Atlanta. Sherry, in addition to helping in MAG's statewide PR efforts, will assist county medical societies in designing and implementing their own PR projects.

The third recommendation made by the PR Committee last year was amended by the House to read: "MAG mount a major PR campaign to improve the physicians' image and to promote the private practice of medicine as outlined in this report."

As to the first part of that recommendation, MAG, on May 2nd, became the first state medical society in the country to launch a program of providing free medical care to those who were unemployed. This project, known as Operation Care, was not only reported on favorably by the state's media but nationally as well. The CBS Evening News With Dan Rather even sent a film crew to give coverage of our efforts.

Operation Care was written up on the national wire services and featured in the May 13th issue of *The New York Times*. Newspapers around the state not only gave favorable news coverage to Operation Care but editorialized on our program. *The Atlanta Constitution's* editorial read, "Doctors' Stopgap Measure Admirable." *The Atlanta Journal's* read, "State Doctors Set Example." *The Ledger Enquirer* in Columbus noted, "City Doctors Have A Heart." *The Savannah News* reported on, "The Doctors' Outreach." *The Waycross Herald's* editorial began, "Doctors To Help." And so it went. The state's TV and radio stations responded likewise.

Operation Care (OC) began in Atlanta with over 650 physicians participating and spread to Columbus, Savannah, Albany, Augusta, and Athens. MAG has encouraged county medical societies to continue Operation Care, and in addition to the county societies named above, (at this writing) the societies of Walton, Clayton-Fayette, Newton-Rockdale, and DeKalb have continued the work of Operation Care.

Not only did Operation Care represent physicians at their finest to the public, it served as the vehicle for the Auxiliary and physicians to work closely together in a program with excellent PR benefits. The Auxiliary is to be commended for the excellent cooperation in providing volunteers to staff the phone lines in the Atlanta area for over eight months of the OC program.

The PR Committee has had problems concerning the second point of the PR Committee's third recommendation last year which read, "to promote the private practice of medicine as outlined in this report."

The Medical Practice Committee has diligently worked to come up with an acceptable definition of "private practice." Their definition was rejected by the Board of Directors at its September meeting. At the January Board meeting, the Board approved the following position statement on the definition of private practice:

> "The private practice of medicine is defined as delivery of medical care carried out in a direct personal relationship in which direct responsibility for care and payment exists between the patient and physicians. MAG supports the environment which allows for maximum freedom of choice for both the patient and physician to select the location of the delivery of care, alternatives of treatment and method of payment for services rendered."



S. William Clark, Jr., Waycross, assumes the new leadership role as President of the MAG for 1984-85.

The PR Committee, following the Board's acceptance of this definition, asked for guidance and direction as to what the Board wished the PR Committee to do in implementing the House's action on promoting the private practice of medicine. The Board directed the Committee "to continue to work to advance the cause of private practice by a PR campaign to promote the principles and policies of medicine as enunciated by MAG."

Your PR Committee will continue to promote private practice in a variety of ways. Brochures which can be used in physicians' offices to help the physician in his patient/physician relations continue to be available. The "I Want To Know What You Think" brochures are available at $2 per hundred.

The PR Committee and the Medical Practice Committee have produced an HMO brochure. These were made available in areas of the state where HMOs were in operation.

The PR Committee's newest brochure is "Selecting A Physician" which is being distributed via Welcome Wagons and other groups and agencies that welcome newcomers to local communities. These are available to county medical societies as well. This brochure emphasizes the benefits of having a personal physician.

We have continued to issue news releases when appropriate as well as letters to the editor. Further, meetings with editorial boards of the state's major newspapers are encouraged by county medical societies.

We had planned a statewide PR workshop scheduled for May 14, 1983, but that workshop was cancelled because of the low number of pre-registrants. We are planning a series of meetings with county medical societies discussing PR. Recent meetings of this type have been held in Augusta and Gainesville.

Letters have been sent to all county medical society presidents, secretaries and staff asking that they schedule PR as the progam for one of their society's meetings.

Letters were also sent to all MAG committee chairmen asking them to review their committee's work to see how the PR Committee may assist them.

Part of our efforts must be directed towards our own MAG membership, and we are pleased to report that a slideshow has been prepared for this House of Delegates on the benefits of MAG membership. A separate PR slide show for county medical societies is in the works.

One of the two objectives of the Medical Association of Georgia is the betterment of public health. Your PR Committee is in the midst of three campaigns directed at this objective. The first is a billboard campaign to help the public become knowledgeable of a law that is to take effect on July 1 of this year. This law, which has the support of MAG, is commonly called the child restraint law. Your PR Committee is assisting the Medicine and Human Values Committee in preparing billboards on this subject.

We are also working in conjunction with the Georgia Sheriff's Association in getting the billboards donated as a public service.

The second project in promoting the betterment of public health is a child abuse campaign. The PR Committee, back in September, agreed to a joint campaign on child abuse with the Department of Human Resources.

We are now at the point of finalizing our plans and beginning production of the materials needed to carry out this project. To give you more specifics of this campaign, we are preparing three TV spots on child abuse; two taped radio spots to be sent to 50 major stations and the two Georgia radio networks; three written radio spots to be sent to all stations; an original song "It's OK to Tell" to establish the theme of the campaign; news and feature releases; information kits for county medical societies with county information on child abuse; a slide/tape show for community meetings; a kick-off reception in which we hope the Governor will participate; an MAG child abuse exhibit which can be displayed at malls, etc.; articles to be submitted to MAG's *Journal;* a puppet show for the Auxiliary to show to school children; a TV documentary on the child abuse problem; and a number of other activities.

The third PR campaign that we are working on is a public awareness effort aimed at reducing Georgia's extremely high infant mortality rate. Georgia currently ranks 49th among the states in such statistics. Our PR efforts are to assist the Maternal and Infant Health Committee and the M & I Task Force in promoting early prenatal care. We are also interested in finding out, from teenagers themselves, their suggestions for lowering teenage pregnancies.

Each of these three campaigns should not only benefit the betterment of public health but will surely yield MAG some very positive PR results just as was the case of the Operation Care program.

The other PR activities include a "how to" PR manual which is being prepared for use by county medical societies. This will be completed this fiscal year. The other is a PR slide show suitable for showing at meetings of county medical societies. This will also be available by June.

Our PR budget request this year is some $20,000 lower than our request last year and the same figure that the House approved last year — $60,000. That figure, incidentally, represents some 3.3% of MAG's total budget for 1984-85.

Several of the PR Committee's projects currently underway will continue throughout much of 1984-85. Not only are we very proud that the Association has decided to make PR a top priority, but we are very proud of the many activities of the Committee and our staff, Mr. Ken Williams and Ms. Sherry Waronker, in our newly created PR Department.

Recommendation

That this 1984 MAG House of Delegates reaffirm that public relations should continue as a top priority of the Association and that all MAG physician members and county medical societies continue to be encouraged that the patient's welfare must always be our number one concern.

House Action

The House adopted the recommendation of the report and added the following: "and wishes to emphasize that PR is most effectively practiced in the physician's office between the patient and the physician and the patient and the physician's office staff."

Committee on Computer Education

William M. McClatchey, M.D., Chairman

On February 12, 1984, the MAG Executive Committee created a new Committee on Computer Education, with the following charge:

> The Committee will oversee the Association's marketing activities for the AMA/GTE Medical Information Network; and as part of those activities will conduct programs to educate physicians on the application of computers in the medical office.

The AMA/GTE Medical Information Network (MINET) — Background

In the past, the ability to practice medicine has been greatly enhanced periodically by striking improvements in technology. By 1980, it was apparent that such an opportunity to exploit technical advancements existed. Unusual achievements in microelectronics had made a profound difference in costs and capabilities in the fields of communication, information storage and retrieval, and rapid computation. Incorporation of many of these innovations into a unified network for the purpose of developing a computerized information support system for the practicing physician appeared possible. In 1980, AMA staff began working with the staff of General Telephone and Electronics in the development of a computer-based medical information data base that could be accessed via Telenet, the GTE telecommunications network.

There was an obvious need for such a system because of the recognized information overload and need for more rapid communication in the medical field. In an AMA study of continuing medical education, 37% of the physicians expressed a desire to have access to a computer terminal through which they could obtain information on diagnosis, treatment, decision algorithms, and bibliographic information at the time they are formulating diagnostic and therapeutic plans. An impressive 66% of respondents also indicated they would like access to computer-based self-assessment programs. The medical profession needed and wanted a computer-based medical

information data base that was continually updated and accessible everywhere via an electronic network.

The system became operational for limited testing in July 1982. In September, the AMA announced that MINET would begin full operation on October 1, 1982.

Structure of the Network

The GTE Telenet Communications Corporation, a subsidiary of GTE and based near Washington D.C., manages and operates the medical information network. The AMA is the principal provider of scientific information offered through the network. The data is licensed and maintained under the name AMA/NET.

A wide variety of computer terminals (video display and/or printer) may be used to link the physician subscriber with the network's data banks in Vienna, Virginia. Connection may be made through existing telephone lines and, in most cases, the physician need only dial a local telephone for network access. This is because there are over 330 "nodes" in the system, located in cities across the country. Where there is no local node, the network can be accessed by means of a long-distance call or a WATS line.

Data Bases

MINET features six types of information services, which subscribers may use:

The *Drug Information* base contains evaluative, up-to-date and unbiased information on the clinical use of drugs. More than 1500 individual drug preparations marketed under some 5,000 trade names in the United States, Canada, and Mexico are described in detail. Users will not only be able to obtain comprehensive information for each drug by name but will be able to identify drugs according to indications for therapy, special patient circumstances, or for certain drug actions and interactions.

The *Disease Information* base contains current, succinct descriptions of diseases, disorders, and conditions. The important diagnostic features of more than 3500 identifiable diseases are summarized in a systematic manner, using preferred standard terminology. The disease base is organized in such a way that users can request information on a specific disease in its entirety or for certain subtopics under the disease listing.

The *Socio/Economic Bibliographic Information* base serves as a guide for locating current articles on the nonclinical aspects of health care. More than 700 journals are monitored on a continuing basis, making this the most comprehensive bibliographic resource of its kind. Other sources include legislative reports, books, and selected newspapers.

The following subjects are covered as they relate to health care and health care providers: economics, education, ethics, international relations, legislation, medical practice, political science, psychology, public health, sociology, statistics.

The *Empires* index to clinical literature aids subscribers in locating recent articles and peer-reviewed papers that have appeared in more than 300 medical and scientific journals worldwide. (EMPIRES stands for Excerpta Medica Physicians Information Retrieval and Education Service.)

The periodicals selected for inclusion in this service cover some 78 medical specialties and subspecialties and represent publications considered to be of greatest value to practicing physicians and other health care professionals in the United States.

Exceptionally easy to use, EMPIRES requires no formal training in computer-based information retrieval system. A unique feature is its Current Awareness Service. By simply keying in an AMA medical specialty code, subscribers can receive citations and abstracts of all relevant articles added to the data base within the past three months. The accompanying Reference Service enables users to extend searches over more variable time spans or to use more specific search criteria.

The *Continuing Education Programs* (developed by Massachusetts General Hospital) enable physicians to earn Category 1 CME credits through a series of interactive computer programs. Current programs cover more than 20 different clinical management areas.

The system provides individualized, self-paced learning based upon computer-simulated patient encounters. Cases are designed to convey the essentials of efficient diagnosis and effective patient management in regard to priority, safety, cost, and temporal sequencing of decisions.

The *Medical Procedure Coding* and *Nomenclature Information* base provides a uniform coding and nomenclature system for reporting medical services and procedures performed by physicians. It contains more than 6,000 descriptions of procedures with their identifying codes in the areas of medicine, surgery, and diagnostic services. Derived from the AMA publication *Physicians' Current Procedural Terminology (CPT),* it is the most widely used of all systems for reporting and communications with third party payers.

Med/Mail

Another integral part of the GTE Telenet Medical Information Network is an electronic mail service called MED/MAIL. MED/MAIL electronic mail provides a fast and reliable means of communication within the medical and health care community. With the same terminal used for retrieving medical information, subscribers can read, send, and even file messages electronically using a computer terminal. Once a message is sent, it is immediately deposited into the recipient's electronic "mail box" where it can be read at his or her convenience 24 hours a day from any city in the United States. More than a person-to-person message service, MED/MAIL also serves as a central source of information on Continuing Medical Education activities, AMA meetings, and for many other services offered through the GTE Telenet Medical Information Network. Easy to learn and use, MED/MAIL incorporates many time-saving features for the busy professional.

Cost

MINET information services will cost $25-$27 per hour, depending on the data base used. MED/MAIL will cost $7-$16 per hour, based on the time of day the service is employed. A basic subscription fee of $100 will be charged.

The Role of the MAG

The Medical Association of Georgia has signed a contract, effective February 1, 1984, with the GTE Telenet Communications Corporation to market the GTE Medical Information Network among Georgia physicians. This is a large undertaking, but we hope to sign up 140 Georgia

physicians as MINET subscribers in the next year.

Our marketing plan will have two main aspects:

I. *Educational Seminars*
Before a physician can subscribe to MINET, he must have a computer or terminal and must feel comfortable using it. Therefore, as our first step, we plan to conduct a number of seminars to educate physicians on the applications of computers in medicine, similar to the one we held February 4-5 in Atlanta. We are thinking of a one-day seminar which we can hold at least four times during the next six months. Preferred sites would be Augusta, Savannah, Macon, and Columbus. There could be others as well.

II. *GTE Promotion and Demonstration*
   a. We plan to *print brochures* giving information on how Georgia physicians can subscribe to MINET.
   b. We hope to kick off our campaign with a special issue of the MAG *Journal* devoted to computers in medicine, with two or three articles written by physicians knowledgeable in the field. We would like for the cover of that issue to feature GTE MINET; we would also run ads for MINET in subsequent issues of *JMAG*.
   c. We will likely hold a *"marketing strategy session"* with GTE marketers in our sister state medical associations. Alabama, Florida, South Carolina, and Tennessee are all marketing MINET, and we agree that we should share successful ideas.
   d. We will *demonstrate MINET* with "hands-on" sessions at county medical society and state specialty society meetings. MINET demonstration will of course be featured in all MAG computer seminars. It seems logical that we also have demonstrations at our House of Delegates.
   e. Among individual physicians, our most concentrated efforts will be directed toward members of the MAG Executive Committee and Board of Directors. Eventually we would like to get MINET in place at our larger county society headquarters. Hospital libraries have already shown interest in subscribing from MAG.

To help with these efforts, especially by allowing us to demonstrate MINET to physicians' meetings around the state, we are calling upon the help of our county medical societies with the following recommendations.

As Chairman, I would like to thank the following MAG members for agreeing to serve on this committee in the coming year:

Edward D. Biggerstaff, III, M.D. — Savannah
Floyd P. Garrett, M.D. — Atlanta
William M. Headley, M.D. — Milledgeville
Richard C. Mattison, M.D. — Atlanta
Jack F. Menendez, M.D. — Macon
James H. Sullivan, M.D. — Columbus

Recommendation

That the MAG shall call upon its component county medical societies for assistance in promoting the AMA/GTE Medical Information System among our members through county society meetings, county newsletters, and other appropriate means.

House Action

Adopted.

Special Resolution A

Affiliate Membership for James D. Anderson, D.D.S.

MAG Judicial Council

RESOLVED, that the Medical Association of Georgia House of Delegates approve Dr. Anderson as an affiliate member of the Association.

House Action

Adopted.

Resolution 1

Athletic Injuries

Hall County Medical Society

RESOLVED, that the Medical Association of Georgia request the Georgia High School Association to consider possible remedies for serious or fatal heat stroke or injury to high school athletes participating in football training by starting football training at a later date in the year and limiting the total number of games played.

House Action

Directed that this resolution be referred to the appropriate committee for consideration.

Resolution 4

Safety on Horseback

Richmond County Medical Society

RESOLVED, that the Medical Association of Georgia promote the need for educational programs to be given to parents, riding instructors, show organizers, and managers, outlining the risks of horseback riding and methods to minimize them, and be it further

RESOLVED, that the Medical Association of Georgia recommend that a satisfactory protective headgear be selected for each type of riding activity and worn when riding or preparing to ride, and be it further

RESOLVED, that the Medical Association recommend that riding schools, horse shows, and other equestrian events be urged to require that protective headgear be worn during the activities.

House Action

Directed that this resolution be referred to the appropriate committee for consideration.

Resolution 5

Smoking

Bibb County Medical Society

RESOLVED, there shall be no smoking in any of the meeting rooms during any MAG Session. This would apply to all Board of Directors meetings and Executive Board meetings. Let those who represent the healing arts set the example.

House Action

Adopted.

Resolution 17

Liability Insurance Coverage for Treatment of State Health Department Patients

Dougherty County Medical Society

RESOLVED, that the Medical Association of Georgia request the Georgia Board of Human Resources to provide a mechanism for liability insurance coverage or protection from suits, for those private practice physicians who treat patients in the county health departments for both physical and mental disorders, as county health department consultants without remuneration.

House Action

Directed that this resolution be referred for study and recommendation of methods of providing the immunity on liability protection as is the intent of this resolution.

Resolution 25

Restructuring (AMA Corporate Structure)

F. William Dowda, M.D., Delegate

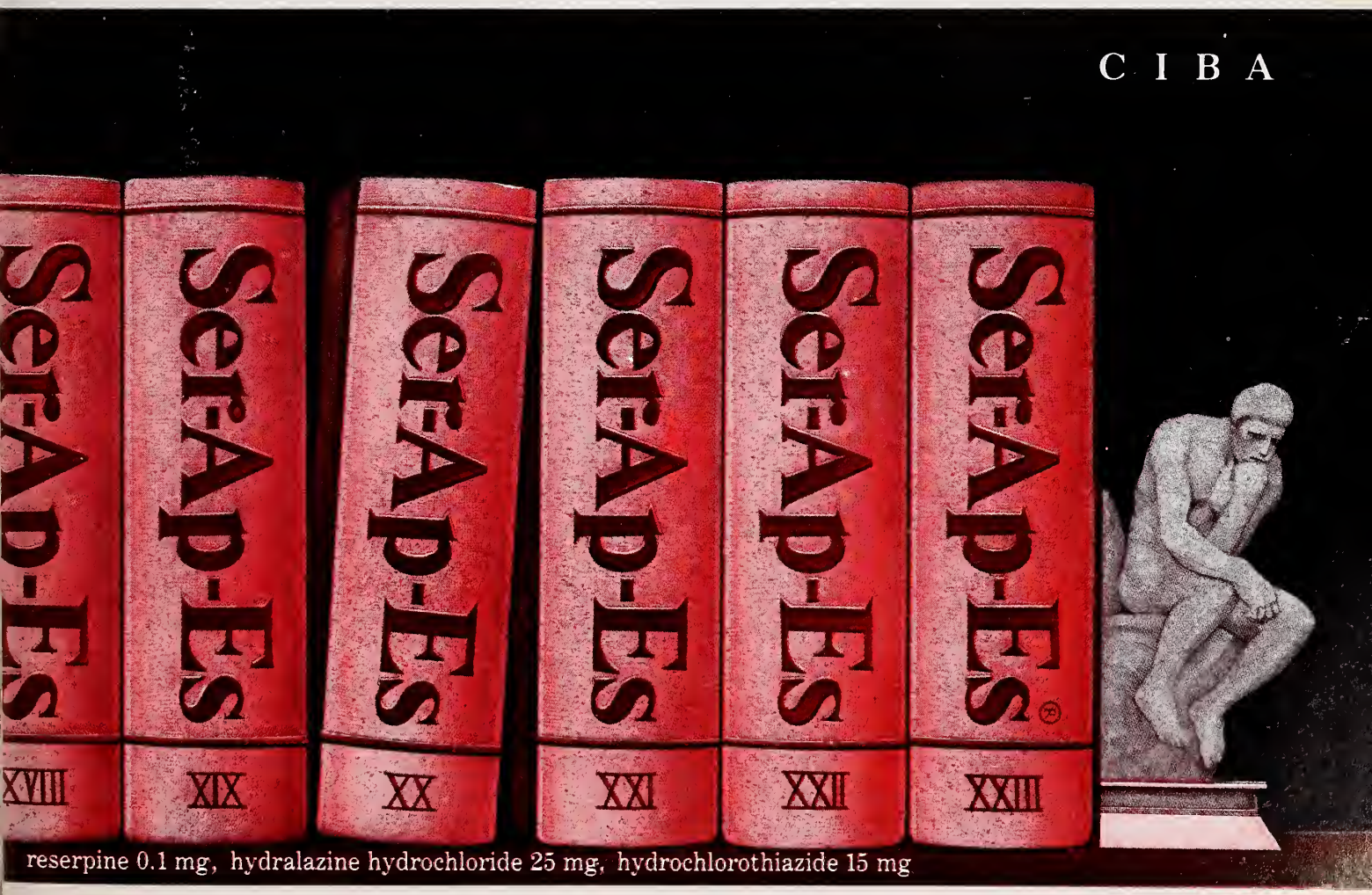
RESOLVED, that the AMA Board maintain a hands-on position on the subsidiary Boards insofar as is legally prudent so that the original purpose of the AMA to be a service organization to patients and physicians be maintained, and be it further

RESOLVED, that this resolution be passed on to the AMA House of Delegates for further discussion and implementation.

House Action

Adopted the first Resolve.

Adopted an amended second Resolve to read: "RESOLVED, that this resolution be passed on to the AMA House of Delegates at its June, 1984, meeting for further discussion and implementation.



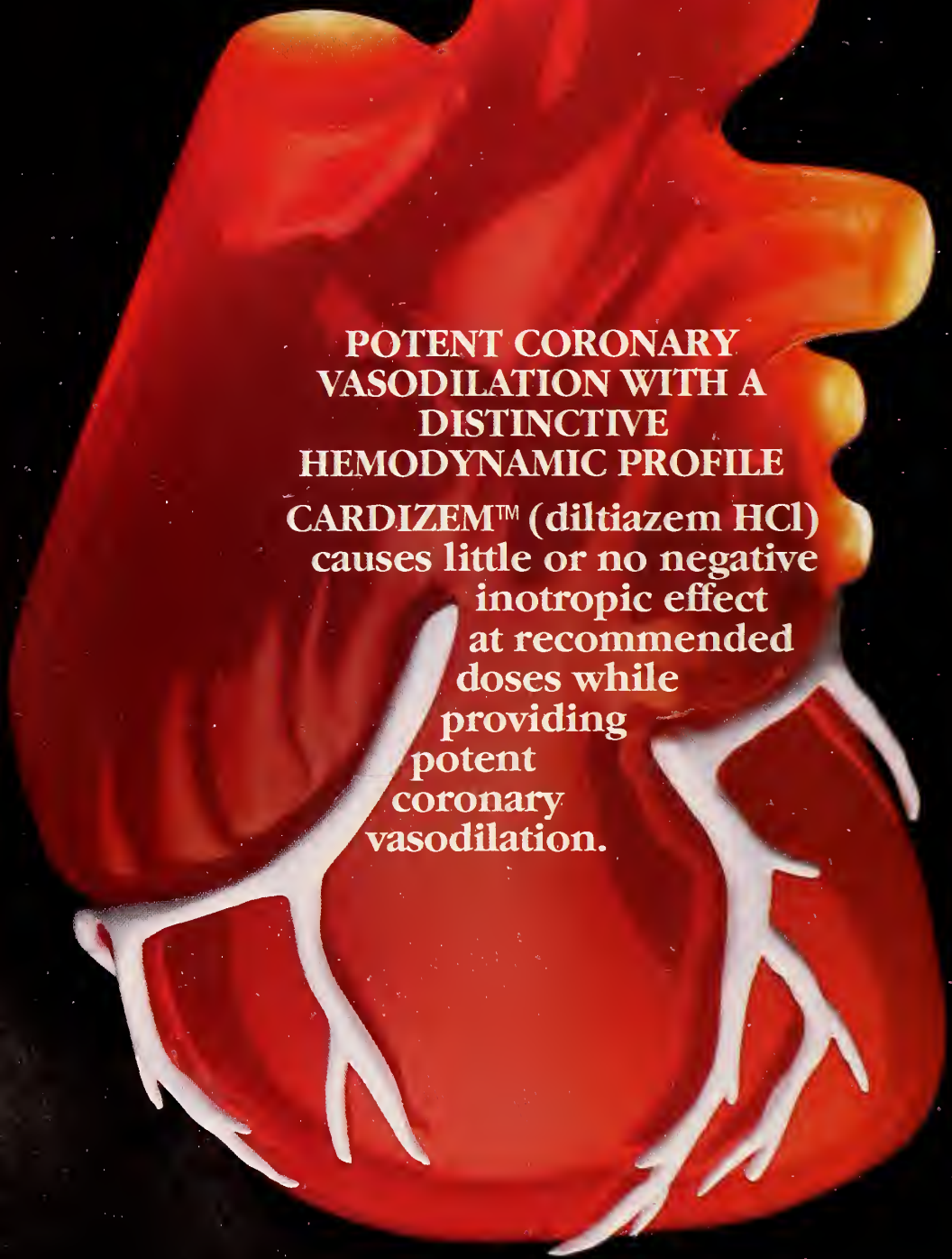
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30 mg and 60 mg tablets

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CARDIZEM™ (diltiazem HCl) causes little or no negative inotropic effect at recommended doses while providing potent coronary vasodilation.

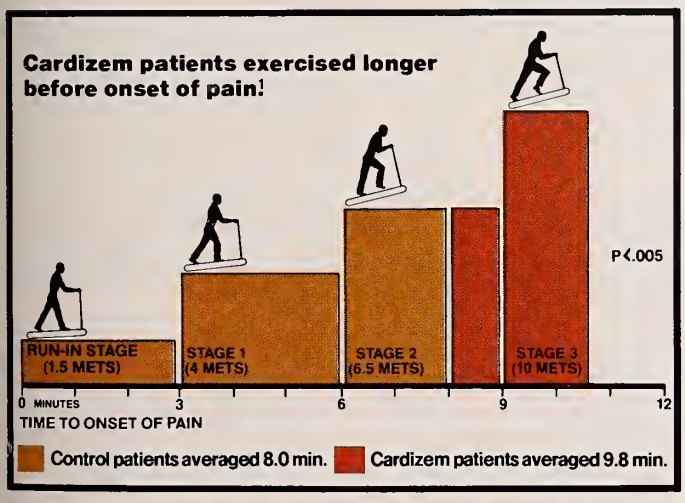
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(diltiazem HCl)
30 mg and 60 mg tablets

INCREASES EXERCISE TOLERANCE, REDUCES ANGINAL FREQUENCY* WITH A LOW INCIDENCE OF SIDE EFFECTS

Calcium channel blockade with CARDIZEM™ (diltiazem HCl) produces changes in cardiovascular hemodynamics and coronary blood flow that are of benefit in myocardial ischemia.

CARDIZEM™ (diltiazem HCl) ALLOWS PATIENTS TO SIGNIFICANTLY PROLONG EXERCISE TOLERANCE, EVEN IN DEMANDING BRUCE PROTOCOL EXERCISE TESTS[1] (n = 15)†



This study is of special significance because patients not only exercised longer but *to the next higher stage* in the Bruce protocol.

A Bruce protocol with a run-in stage was used for all tests. Each stage lasts three minutes.

In other studies, Cardizem produced 41% to 68% reduction of Prinzmetal's variant angina attacks[2]

†This study is a report from one center in a multicenter study.

Therapy with Cardizem produced a low incidence of side effects.

In placebo-controlled trials (222 patients) conducted in the United States, the incidence of adverse reactions reported during Cardizem therapy was not greater than that reported during placebo therapy.

Those adverse reactions reported most frequently with Cardizem in 959 patients in controlled and uncontrolled U.S. trials have been:

- Nausea 2.7%
- Swelling/edema 2.4%
- Arrhythmia 2.0%
- Headache 2.0%
- Rash 1.8%
- Fatigue 1.1%

Other reactions reported infrequently (less than 1%) are listed in full prescribing information on adjacent page.

References:

1. Pool PE, Seagren SC, Bonanno JA, et al: The treatment of exercise-inducible chronic stable angina with diltiazem: Effect on treadmill exercise. *Chest* 78 (July suppl): 234-238, 1980.
2. Schroeder JS, Feldman RL, Giles TD, et al: Multiclinic controlled trial of diltiazem for Prinzmetal's angina. *Am J Med* 72:227-232, 1982.

Please see adjacent page for full prescribing information.

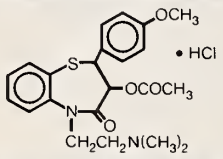
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PROFESSIONAL USE INFORMATION

cardizem™
(diltiazem HCl)
30 mg and 60 mg tablets

DESCRIPTION

CARDIZEM™ (diltiazem hydrochloride) is a calcium ion influx inhibitor (slow channel blocker or calcium antagonist). Chemically, diltiazem hydrochloride is 1,5-Benzothiazepin-4(5H)one,3-(acetyloxy)-5-[2-(dimethylamino)ethyl]-2,3-dihydro-2-(4-methoxyphenyl)-, monohydrochloride,(+)-cis-. The chemical structure is:



Diltiazem hydrochloride is a white to off-white crystalline powder with a bitter taste. It is soluble in water, methanol, and chloroform. It has a molecular weight of 450.98. Each tablet of CARDIZEM contains either 30 mg or 60 mg diltiazem for oral administration.

CLINICAL PHARMACOLOGY

The therapeutic benefits achieved with CARDIZEM are believed to be related to its ability to inhibit the influx of calcium ions during membrane depolarization of cardiac and vascular smooth muscle.

Mechanisms of Action. Although precise mechanisms of its antianginal actions are still being delineated, CARDIZEM is believed to act in the following ways:

1. Angina Due to Coronary Artery Spasm: CARDIZEM has been shown to be a potent dilator of coronary arteries both epicardial and subendocardial. Spontaneous and ergonovine-induced coronary artery spasm are inhibited by CARDIZEM.
2. Exertional Angina: CARDIZEM has been shown to produce increases in exercise tolerance, probably due to its ability to reduce myocardial oxygen demand. This is accomplished via reductions in heart rate and systemic blood pressure at submaximal and maximal exercise work loads.

In animal models, diltiazem interferes with the slow inward (depolarizing) current in excitable tissue. It causes excitation-contraction uncoupling in various myocardial tissues without changes in the configuration of the action potential. Diltiazem produces relaxation of coronary vascular smooth muscle and dilation of both large and small coronary arteries at drug levels which cause little or no negative inotropic effect. The resultant increases in coronary blood flow (epicardial and subendocardial) occur in ischemic and nonischemic models and are accompanied by dose-dependent decreases in systemic blood pressure and decreases in peripheral resistance.

Hemodynamic and Electrophysiologic Effects. Like other calcium antagonists, diltiazem decreases sinoatrial and atrioventricular conduction in isolated tissues and has a negative inotropic effect in isolated preparations. In the intact animal, prolongation of the AH interval can be seen at higher doses.

In man, diltiazem prevents spontaneous and ergonovine-provoked coronary artery spasm. It causes a decrease in peripheral vascular resistance and a modest fall in blood pressure and, in exercise tolerance studies in patients with ischemic heart disease, reduces the heart rate/blood pressure product for any given work load. Studies to date, primarily in patients with good ventricular function, have not revealed evidence of a negative inotropic effect; cardiac output, ejection fraction, and left ventricular end diastolic pressure have not been affected. There are as yet few data on the interaction of diltiazem and beta-blockers. Resting heart rate is usually unchanged or slightly reduced by diltiazem.

Intravenous diltiazem in doses of 20 mg prolongs AH conduction time and AV node functional and effective refractory periods approximately 20%. In a study involving single oral doses of 300 mg of CARDIZEM in six normal volunteers, the average maximum PR prolongation was 14% with no instances of greater than first-degree AV block. Diltiazem-associated prolongation of the AH interval is not more pronounced in patients with first-degree heart block. In patients with sick sinus syndrome, diltiazem significantly prolongs sinus cycle length (up to 50% in some cases).

Chronic oral administration of CARDIZEM in doses of up to 240 mg/day has resulted in small increases in PR interval, but has not usually produced abnormal prolongation. There were, however, three instances of second-degree AV block and one instance of third-degree AV block in a group of 959 chronically treated patients.

Pharmacokinetics and Metabolism. Diltiazem is absorbed from the tablet formulation to about 80% of a reference capsule and is subject to an extensive first-pass effect, giving an absolute bioavailability (compared to intravenous dosing) of about 40%. CARDIZEM undergoes extensive hepatic metabolism in which 2% to 4% of the unchanged drug appears in the urine. In vitro binding studies show CARDIZEM is 70% to 80% bound to plasma proteins. Competitive ligand binding studies have also shown CARDIZEM binding is not altered by therapeutic concentrations of digoxin, hydrochlorothiazide, phenylbutazone, propranolol, salicylic acid, or warfarin. Single oral doses of 30 to 120 mg of CARDIZEM result in detectable plasma levels within 30 to 60 minutes and peak plasma levels two to three hours after drug administration. The plasma elimination half-life following single or multiple drug administration is approximately 3.5 hours. Desacetyl diltiazem is also present in the plasma at levels of 10% to 20% of the parent drug and is 25% to 50% as potent as a coronary vasodilator as diltiazem. Therapeutic blood levels of CARDIZEM appear to be in the range of 50 to 200 ng/ml. There is a departure from dose-linearity when single doses above 60 mg are given; a 120-mg dose gave blood levels three times that of the 60-mg dose. There is no information about the effect of renal or hepatic impairment on excretion or metabolism of diltiazem.

INDICATIONS AND USAGE

1. **Angina Pectoris Due to Coronary Artery Spasm.** CARDIZEM is indicated in the treatment of angina pectoris due to coronary artery spasm. CARDIZEM has been shown effective in the treatment of spontaneous coronary artery spasm presenting as Prinzmetal's variant angina (resting angina with ST-segment elevation occurring during attacks).
2. **Chronic Stable Angina (Classic Effort-Associated Angina).** CARDIZEM is indicated in the management of chronic stable angina in patients who cannot tolerate therapy with beta-blockers and/or nitrates or who remain symptomatic despite adequate doses of these agents. CARDIZEM has been effective in short-term controlled trials in reducing angina frequency and increasing exercise tolerance, but confirmation of sustained effectiveness is incomplete.

There are no controlled studies of the effectiveness of the concomitant use of diltiazem and beta-blockers or of the safety of this combination in patients with impaired ventricular function or conduction abnormalities.

CONTRAINDICATIONS

CARDIZEM is contraindicated in (1) patients with sick sinus syndrome except in the presence of a functioning ventricular pacemaker, (2) patients with second- or third-degree AV block, and (3) patients with hypotension (less than 90 mm Hg systolic).

WARNINGS

1. **Cardiac Conduction.** CARDIZEM prolongs AV node refractory periods without significantly prolonging sinus node recovery time, except in patients with sick sinus syndrome. This effect may rarely result in abnormally slow heart rates (particularly in patients with sick sinus syndrome) or second- or third-degree AV block (four of 959 patients for 0.42%). Concomitant use of diltiazem with beta-blockers or digitalis may result in additive effects on cardiac conduction. A patient with Prinzmetal's angina developed periods of asystole (2 to 5 seconds) after a single dose of 60 mg of diltiazem.
2. **Congestive Heart Failure.** Although diltiazem has a negative inotropic effect in isolated animal tissue preparations, hemodynamic studies in humans with normal ventricular function have not shown a reduction in cardiac index nor consistent negative effects on contractility (dp/dt). Experience with the use of CARDIZEM alone or in combination with beta-blockers in patients with impaired ventricular function is very limited. Caution should be exercised when using the drug in such patients.
3. **Hypotension.** Decreases in blood pressure associated with CARDIZEM therapy may occasionally result in symptomatic hypotension.
4. **Acute Hepatic Injury.** There has been a single report in a patient receiving 120 mg of diltiazem tid of marked transaminase elevation (SGOT 4500, SGPT 2300) accompanied by hyperbilirubinemia (to 3 mg%), occurring after four days of treatment. The enzyme abnormalities resolved entirely, and enzymes were nearly normal a week after cessation of treatment. No rechallenge was carried out, but the patient had no evidence of viral hepatitis and received no other drugs but isosorbide dinitrate.

   No other similar liver injury has been reported in clinical trials, but marketing experience in Europe has resulted in a rechallenge-confirmed instance of hepatocellular injury. However, it should be noted that there have been further episodes of raised transaminases in the absence of diltiazem in this patient, so that the relationship to diltiazem of the abnormalities is not completely clear. Other instances of transaminase elevation have been reported in Europe, but their relationship to the drug is uncertain.

PRECAUTIONS

General. CARDIZEM is extensively metabolized by the liver and excreted by the kidneys and in bile. As with any new drug given over prolonged periods, laboratory parameters should be monitored at regular intervals. The drug should be used with caution in patients with impaired renal or hepatic function. In subacute and chronic dog and rat studies designed to produce toxicity, high doses of diltiazem were associated with hepatic damage. In special subacute hepatic studies, oral doses of 125 mg/kg and higher in rats were associated with histological changes in the liver which were reversible when the drug was discontinued. In dogs, doses of 20 mg/kg were also associated with hepatic changes; however, these changes were reversible with continued dosing.

Drug Interaction. Pharmacologic studies indicate that there may be additive effects in prolonging AV conduction when using beta-blockers or digitalis concomitantly with CARDIZEM. (See WARNINGS.)

Uncontrolled domestic studies suggest that concomitant use of CAROIZEM and beta-blockers or digitalis is usually well tolerated. Available data are not sufficient, however, to predict the effects of concomitant treatment, particularly in patients with left ventricular dysfunction or cardiac conduction abnormalities; the effect of diltiazem on serum digoxin levels has not been examined. The safety of the combination of CARDIZEM and beta-blockers or digitalis is currently being investigated in well-controlled studies.

Carcinogenesis, Mutagenesis, Impairment of Fertility. A 24-month study in rats and a 21-month study in mice showed no evidence of carcinogenicity. There was also no mutagenic response in in vitro bacterial tests. No intrinsic effect on fertility was observed in rats.

Pregnancy. Category C. Reproduction studies have been conducted in mice, rats, and rabbits. Administration of doses ranging from five to ten times greater (on a mg/kg basis) than the daily recommended therapeutic dose has resulted in embryo and fetal lethality. These doses, in some studies, have been reported to cause skeletal abnormalities. In the perinatal/postnatal studies, there was some reduction in early individual pup weights and survival rates. There was an increased incidence of stillbirths at doses of 20 times the human dose or greater.

There are no well-controlled studies in pregnant women; therefore, use CARDIZEM in pregnant women only if the potential benefit justifies the potential risk to the fetus.

Nursing Mothers. It is not known whether this drug is excreted in human milk. Because many drugs are excreted in human milk, exercise caution when CARDIZEM is administered to a nursing woman if the drug's benefits are thought to outweigh its potential risks in this situation.

Pediatric Use. Safety and effectiveness in children have not been established.

ADVERSE REACTIONS

Serious adverse reactions have been rare in studies carried out to date, but it should be recognized that patients with impaired ventricular function and cardiac conduction abnormalities have usually been excluded. Experience with an added beta-blocker is also extremely limited.

In domestic placebo-controlled trials, the incidence of adverse reactions reported during CARDIZEM therapy was not greater than that reported during placebo therapy.

In addition, the following have been reported infrequently and represent occurrences which can be at least reasonably associated with the pharmacology of calcium influx inhibition. In many cases, the relationship to CARDIZEM has not been established. The most common occurrences, as well as their frequency of presentation, are nausea (2.7%), swelling/edema (2.4%), arrhythmia (2.0%), headache (2.0%), rash (1.8%), and fatigue (1.1%). In addition, the following events were reported infrequently (<1.0%). The order of presentation corresponds to the relative frequency of occurrence.

Cardiovascular:	Flushing, congestive heart failure, bradycardia, hypotension, syncope, pounding heart.
Central Nervous System:	Drowsiness, dizziness, lightheadedness, nervousness, depression, weakness, insomnia, confusion, hallucinations.
Gastrointestinal:	Vomiting, diarrhea, gastric upset, constipation, indigestion, pyrosis.
Dermatologic:	Pruritus, petechiae, urticaria.
Other:	Photosensitivity, nocturia, thirst, paresthesias, polyuria, osteoarticular pain.

The following additional experiences have been noted:

A patient with Prinzmetal's angina experiencing episodes of vasospastic angina developed periods of transient asymptomatic asystole approximately five hours after receiving a single 60-mg dose of CARDIZEM.

Experience in 959 patients taking oral doses of CARDIZEM resulted in three cases (0.31%) of second-degree AV block and one case (0.10%) of third-degree AV block at doses of 240 to 360 mg daily.

In rare instances, mild to moderate transient elevations of alkaline phosphatase, SGOT, SGPT, LDH, and CPK have been noted during CARDIZEM therapy. A single incident of markedly elevated liver enzymes associated with symptoms was reported in a patient taking 360 mg per day for four days. Drug was discontinued and enzymes normalized within 1 week.

OVERDOSAGE OR EXAGGERATED RESPONSE

Overdosage experiences with oral diltiazem have not been reported. Single oral doses of 300 mg of CAROIZEM have been well tolerated by healthy volunteers. In the event of overdosage or exaggerated response, appropriate supportive measures should be employed in addition to gastric lavage. The following measures may be considered:

Bradycardia	Administer atropine (0.60 to 1.0 mg). If there is no response to vagal blockade, administer isoproterenol cautiously.
High-degree AV Block	Treat as for bradycardia above. Fixed high-degree AV block should be treated with cardiac pacing.
Cardiac Failure	Administer inotropic agents (isoproterenol, dopamine, or dobutamine) and diuretics.
Hypotension	Vasopressors (eg, dopamine or levarterenol bitartrate).

Actual treatment and dosage should depend on the severity of the clinical situation and the judgment and experience of the treating physician.

The oral LD_{50}'s in mice and rats range from 415 to 740 mg/kg and from 560 to 810 mg/kg, respectively. The intravenous LD_{50}'s in these species were 60 and 38 mg/kg, respectively. The oral LD_{50} in dogs is considered to be in excess of 50 mg/kg, while lethality was seen in monkeys at 360 mg/kg. The toxic dose in man is not known, but blood levels in excess of 800 ng/ml have not been associated with toxicity.

DOSAGE AND ADMINISTRATION

Exertional Angina Pectoris Due to Atherosclerotic Coronary Artery Disease or Angina Pectoris at Rest Due to Coronary Artery Spasm. Dosage must be adjusted to each patient's needs. Starting with 30 mg four times daily, before meals and at bedtime, dosage should be increased gradually to 240 mg (given in divided doses three or four times daily) at one- to two-day intervals until optimum response is obtained. The effectiveness and safety of dosages exceeding 240 mg per day are currently being investigated. There are no available data concerning dosage requirements in patients with impaired renal or hepatic function. If the drug must be used in such patients, titration should be carried out with particular caution.

Concomitant Use With Other Antianginal Agents.

1. **Sublingual NTG** may be taken as required to abort acute anginal attacks during CARDIZEM therapy.
2. **Prophylactic Nitrate Therapy**—CARDIZEM may be safely coadministered with short- and long-acting nitrates, but there have been no controlled studies to evaluate the antianginal effectiveness of this combination.
3. **Beta-blockers.** (See WARNINGS and PRECAUTIONS.)

HOW SUPPLIED

CARDIZEM 30-mg tablets are supplied in bottles of 100 (NDC 0088-1771-47). Each green tablet is engraved with MARION on one side and 1771 engraved on the other. CARDIZEM 60-mg scored tablets are supplied in bottles of 100 (NDC 0088-1772-47). Each yellow tablet is engraved with MARION on one side and 1772 on the other.

Issued 11/82

Another patient benefit product from

PHARMACEUTICAL DIVISION
MARION LABORATORIES, INC.
KANSAS CITY, MISSOURI 64137

3/83

Report of Reference Committee B

Richard W. Cohen, M.D., Austell, Chairman
James P. Evans, M.D., Savannah, Vice Chairman

In addition to the Chairman and Vice Chairman named above, the following persons served on Reference Committee B: William Bird Jones, MD, Gainesville; Patton P. Smith, MD, Forsyth; James L. O'Quinn, MD, Augusta; James Q. Whitaker, MD, Warner Robins; Alvin H. Clair, MD, Atlanta; and Dan B. Stephens, MD, Marietta.

Medical Practice Committee

W. Dan Jordan, M.D., Chairman

At its initial meeting for the 1983-84 year, the Medical Practice Committee discussed how to start to address the items which the April House of Delegates referred to this committee:

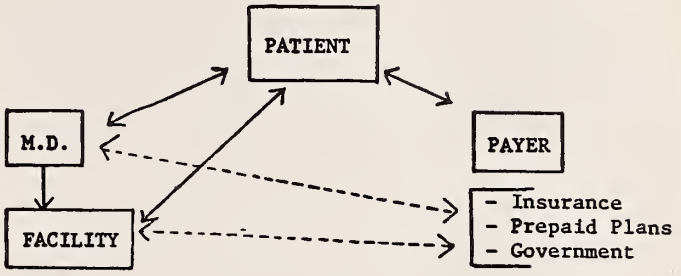
— Panorama of Medical Practice
— Definition of Private Practice of Medicine
— Contractual Practice Arrangements & Preferred Provider Organizations
— Issue of "Closed" vs. "Open" Hospital Medical Staffs

I. *Panorama of Medical Practice*

These discussions ranged from the very basic physician-patient relationship where it is the physician's responsibility to provide medical care and the patient's responsibility to pay for it — to the myriad of "outside" activities and agencies that are impacting on this relationship.

Recognizing that these impacting factors change frequently, it was decided that if the committee could reach a consensus on what the ideal system for delivery of medical care to the most people would be, then the committee would have a reference point to evaluate current practice. Out of these evaluations, the definition of private practice would naturally evolve — the idea being that if we seek the ideal, other factors which seem to be bothering the physician and the patient would be more apparent. The committee approached the development of parameters for an ideal system from different angles with basic components of freedom of choice; the patient, physician, facility, and payer as decision makers or control sources; and the influencing factors of access, quality, cost, and mode of delivery.

Discussion included the ideal from what would be best for each of the decision makers, acknowledging the built-in bias from each source regarding each of the influencing factors. It was the consensus of the committee that the patient is the core of the system. Patients are not only the reasons for having medical care available, they make the initial decision to seek medical care. The committee agreed that the following diagram [at the top of the right hand column] reflects both the ideal (solid line) and the current (broken line) system.



The committee further discussed the following:

"Freedom of Choice" Issues:

— Freedom of physicians to choose their specialty where they practice their mode of delivery, and to select their own patients and set their own charges for their services, as well as the method of payment they deem acceptable.
— Freedom of patients to select providers and their means of paying for the service they receive.
— Freedom of payers to determine what services will cover, how much they will pay, and to whom they will make payment.

The committee perceived that most problems occur when providers and payers negotiate services and payment without direct involvement of the patient.

It considered (1) discussion of attempts to ration medical care and who should make the decision as to what will be provided; (2) the need to make patients more knowledgeable about the medical care they receive, its accessibility and its costs; (3) the legal implications of the fact that quality of care defined by scientific application may be vastly different from the outcome of treatment perceived by the patient as the quality of care received; and (4) the need to get the patient more knowledgeable about and subsequently more involved in making the decisions that directly affect the medical care they receive.

Recommendation 1

The Medical Practice Committee recommends that MAG adopt this outline as an ideal mechanism for delivery of care and as a bench mark to be used for members with which to compare proposed delivery systems.

II. *Definition of Private Practice*

Independence, freedom of choice, ability to set own fees and choose mode of delivery; perceived "stigma" if you are not in private practice; contracting; group practice; corporate practice; medical school faculty and public health services; where does payment come from; is private practice best; what are other types of practice or alternatives — all these were discussed by the committee in reaching its consensus of a definition of private practice which was submitted to the September meeting of the MAG Board of Directors.

At its September '83 meeting, the MAG Board of Directors requested that the Medical Practice Committee reconsider its proposed definition of private practice. Specific questions: Do we need a definition? If so, what other types of practice are there and how are they defined?

In response to these questions, the Medical Practice Committee does recommend that the Association adopt a

definition of private practice to provide a reference point to implement the 1983 House of Delegates direction that "MAG mount a major PR campaign to improve the physician's image and to promote the private practice of medicine as outlined in this report." (PR Committee report to 1983 House of Delegates). The committee also noted that the Board of Directors (September '83 meeting) adopted a recommendation of the Ad Hoc Committee on Freestanding Emergency Centers "that MAG should undertake a media campaign to promote the concept of traditional private practice." The Medical Practice Committee is charged to "encourage the private practice of medicine."

With the advent of all the alternative delivery systems and the daily changing payment mechanisms, what constitutes private practice has become blurred to the extent that its definition almost varies with each physician. This committee also considered a definition of private practice submitted by the Georgia Society of Internal Medicine.

After reconsideration, the committee recommended and the MAG Executive Committee subsequently adopted that the following definition and policy statement on private practice be adopted by the MAG:

Definition

"The private practice of medicine is the delivery of medical care carried out in a direct personal relationship in which direct responsibility for care and payment exists between the patient and physician."

Policy

"MAG supports the environment which allows for maximum freedom of choice for both the patient and physician to select the location of the delivery of care, alternatives of treatment, and method of payment for services rendered."

As to what other types of practice there may be, the committee emphasized that it does not think it appropriate to label physicians, but that the Association should stress the importance of a personal agreement between the patient and the physician as opposed to direct contract between the physician and the third party payer without actual patient involvement. An individual physician may be in both the part-time private practice and part-time contractual practice.

Recommendation 2

The Medical Practice Committee recommends that the Definition of Private Practice and Policy Statement be adopted.

III. *Diagnostic Related Grouping*

A. Hospital DRGs

Based on the recommendation of the Medical Practice Committee, the 1983 MAG House of Delegates reaffirmed its opposition to the concept of prospective pricing on the basis of Diagnosis Related Grouping.

The Association wrote to each member of the Georgia Congressional Delegation about this action.

The September, 1983, meeting of the MAG Board of Directors asked that the Medical Practice Committee answer these questions:

1. Should the MAG take further action?
2. If so, what are some suggestions?

The Medical Practice Committee felt that before any system is mandated nationwide, that system should be fully implemented in trial projects for a prolonged trial period. Despite all the "intensive review" claimed by HCFA, the proposed system has not been tried. Just because it *may* reduce federal expenditure does not mean that medical care costs will be reduced. Therefore, the committee felt the basic premise of the DRG system is wrong — that it is simply another way the political system has made promises it cannot meet and is now shifting that responsibility to the physicians.

The committee members also agreed that the Association should continue to serve as the patient's advocate by refusing to yield to pressure to cut costs by reducing the quality and quantity of medical care the patient needs.

Recommendation 3

The Committee recommends that efforts should be made to delay total implementation until the system has been tried and proved that it can deliver high quality care at a reduced cost.

B. Physician DRGs

The Medical Practice Committee discussed the publicized proposals of including physician payment into the DRG concept and concluded that progress should be impeded in the political process whereby both the physician and the hospital are reimbursed under one DRG, since medical and financial control will be totally transferred to the hospital and taken from both the physician and the patient.

Recommendation 4

1. The Medical Practice Committee recommends that MAG oppose physician DRGs for two reasons:
   (a) Because it is beyond the concept of fixed fees-for-service; and
   (b) Inclusion of physician DRGs into hospital DRGs provides for potential conflict between physicians and hospitals and provides incentives for decreasing care in order to increase reimbursement.

Recommendation 5

2. Seek the development of alternative mechanisms for payment of care that will increase patient awareness and involvement in the reimbursement process.

IV. *Open/Closed Medical Staffs*

At the time of the preparation of this report, the Committee is revising a questionnaire and cover letter to all Georgia hospital chiefs of staff to try to determine the status of "closed" vs. "open" medical staffs in Georgia. Membership will be further advised of the extent of the problem in Georgia and suggestions for alleviation of the problems as they are identified.

V. *Contract Practice & Preferred Provider Organizations*

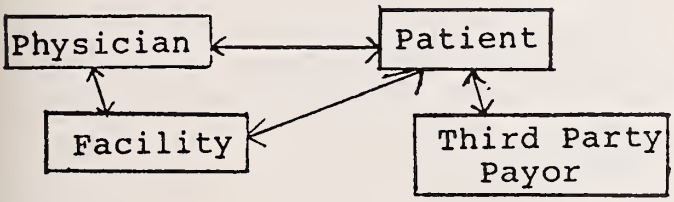
The request of the House of Delegates to expedite distribution of information/guidelines relating to contractual practice arrangements and preferred provider organizations to the MAG membership was met by a letter to the membership from the Chairman of the MAG Board of Directors. A copy of this letter and accompanying brochure is available upon request to MAG Headquarters.

VI. *Information*

The actions re "Panorama" . . . AMA Health Policy Agenda. The AMA approach to dealing with the Panorama of Medical Care — called the AMA Health Policy Agenda — is an enormous undertaking which will span three years. It has two major phases: Phase 1 — *Basic Principles* and Phase 2 — *Health Policy Proposals*. To develop these principles and policies, six work groups have been established on: Medical Science; Education; Health Resources; Delivery Mechanisms/Process, Evaluation Assessment and Control; and Payment for Service. An Advisory Committee representing a very broad base of concerned groups has been established to advise the work groups. The Advisory Committee held its first meeting August 29-30, 1983, and a summary report was distributed to participants in September 1983. The work groups have now revised their reports, and the Advisory Committee will meet again in April to consider implementing the next phase of the operation.

House Action

Recommendation 1: Adopted as amended, change the diagram as follows:



Recommendation 2: Definition adopted as is. Policy adopted as amended: Delete the word "maximum" in the first sentence of the Policy so that as amended the policy reads: "MAG supports the environment which allows for ~~maximum~~ freedom of choice for both the patient and physician to select the location of the delivery of care, alternatives of treatment, and method of payment for services rendered."

Recommendation 3: The House considered this recommendation in conjunction with Resolution 2 (see p. 398) and adopted the following substitute resolution in lieu of Recommendation 3 and Resolution 2:

"RESOLVED, that the Medical Association of Georgia use every facility at its disposal to educate the public of the crisis in our health care system created by DRGs, and be it further

RESOLVED, that the Medical Association of Georgia make full use of its lobbying abilities, both at the state and federal government levels, to bring about a repeal of the DRGs, and be it further

RESOLVED, that the Medical Association of Georgia encourage the American Medical Association to take the lead in a national publicity campaign and legislative effort to achieve the above desired repeal of DRGs."

Recommendation 4: Adopted as amended: "The Medical Practice Committee recommends that MAG oppose physician DRGs."

Recommendation 5: Adopted as amended: "MAG should seek the development of alternative mechanisms of payment of care that would increase patient awareness and involvement in the reimbursement process."

Third Party Relations Committee

A. A. McNeill, Jr., M.D., Chairman

During 1983-84, the Third Party Relations Committee has considered several issues of concern to physicians.

1. 1983-Resolution 17-UCR:
   Usual, Customary, and Reasonable vs. Indemnity Approach for Third Party Payment of Physician fees — The committee recommended to the MAG Board of Directors that the MAG rescind any previous approval of the concept of UCR and that the MAG move in the direction of supporting an indemnity approach. This recommendation was accepted for information by the Board of Directors at its September '83 meeting.
2. Preadmission and Concurrent Review Service:
   In a report from the Greater Atlanta Health Care Coalition, Duane Blair, M.D. (MAG representative), brought it to the attention of the September MAG Board of Directors that the Prudential Insurance Company has instituted its own preadmission and concurrent review mechanism for employer group health contracts. With this concept, the insuror must authorize admission and length of stay for all except emergency admissions of an enrolled client. This concept is not limited to Prudential. There are a number of other employers/carriers that are implementing similar programs. Because of the concern about the qualifications of those responsible for these certifications, some county medical societies are proposing to serve as the certifying agency. The MAG Executive Committee directed the Third Party Relations Committee to monitor the development of these programs.
3. The Atlanta Blue Cross/Blue Shield implemented a Participating Physician Program similar to the one already in existence in the Columbus Blue Cross/Blue Shield area. Basically this plan requires physicians to accept Blue Shield payment as payment-in-full for service provided. Unless benefits are assigned, payment for care provided by a non-participating physician will be made to the patient.
4. Department of Medical Assistance (Georgia Medicaid):
   The committee has and is continuing to negotiate with the DMA in its efforts to improve its claim processing; improve communication with physicians; and to implement TEFRA regulations and other cost-saving options without loss of necessary services.

   To this end a new DMA Physician Advisory Committee and a Hospital-Based Physician Advisory Committee have been appointed. MAG staff continues to work closely with DMA staff to identify ways that payment for hospital-based pathologists (in particular) and home health care may be more equitably administered. During 1983, the DMA has implemented a Mandatory Outpatient Program and is currently (March '84) considering implementation of Mandatory Second Opinions for certain procedures. In response to a DMA request for assistance in developing this program, the MAG Executive Committee (March '84) reaffirmed MAG's position in opposition to the establishment of Mandatory Second Opinions, emphasizing that physicians should request consultations if their patients want one.
5. The committee feels that the whole MAG membership needs to be kept up to date with changing reimburse-



MAG delegates Jack Raines, Bill Dowda, Jim Averett, Milton Johnson, Charles Lanford, Alva Mayes, Bill Headley, Cyler Garner, and Emory Johnson are among the many serving in the 1984 House.

ment decisions being made by third party payers. It has recommended that monies be allocated in MAG's 1984-85 budget to conduct meetings and to mail information about these changes throughout the year.

6. The MAG is in the process of updating its policies and official statements. The Third Party Relations Committee recommended changes in the following statements relating to reimbursement issues: freedom of choice; emergency care for the indigent; clinical criteria lists; and consultations. The policies ultimately adopted regarding these issues will be made available to the membership.

House Action

See House Action for Resolution 24 on page 400.

Resolution 2

Repeal of DRGs

Ogeechee River Medical Society

RESOLVED, by the Ogeechee River Medical Society that we implore the Medical Association of Georgia to use every facility at its disposal including frequent radio and television announcements to educate the public of the crisis in our health care system created by DRGs, and be it further

RESOLVED, that the Medical Association of Georgia make full use of its lobbying abilities, both at the State and Federal government levels, to bring about a repeal of the DRGs, and be it further

RESOLVED, that the Medical Association of Georgia bring the strongest possible pressures upon the American Medical Association to take the lead in a national publicity campaign to achieve the above desired repeal of DRGs.

House Action

See House Action for Recommendation 3 of the Medical Practice Committee on p. 397.

Resolution 7

Employers' Violation of Patient Confidentiality with Group Medical Insurance Claim Forms

Cobb County Medical Society

RESOLVED, that the MAG begin immediate steps seeking a remedy to the problem of employers' violation of employee/patient confidentiality with group medical insurance claim forms, and be it further

RESOLVED, that the MAG Board of Directors direct this resolution to the proper MAG Committee for appropriate action, and be it further

RESOLVED, that the proper Committee consult with legal counsel concerning existing state and federal laws as well as enlisting the aid and support of other groups such as labor unions, mental health associations, etc., and be it further

RESOLVED, that this Committee seek specific rulings from the Georgia Insurance Commissioner's office, if feasible, to assist in safeguarding patient privacy, and be it further

RESOLVED, that MAG seek passage of legislation in the 1985 Georgia General Assembly or class action litigation if necessary, and be it further

RESOLVED, that the proper MAG Committee report its findings to the MAG Board of Directors which shall, in turn, report back to the 1985 MAG House.

House Action

Adopted the first and last resolves.

Resolution 8

Cognitive Services Reimbursement

Alva Louie Mayes, M.D., Delegate
Richard DuBois, M.D., Delegate
Richard Wherry, M.D., Delegate

RESOLVED, that the Medical Association of Georgia support the concept that third party payors should provide more equitable reimbursement for physicians' cognitive services in comparison with their procedural services, and be it further

RESOLVED, that the Medical Association of Georgia take appropriate action to promote this concept with third party payors (including government), business groups and coalitions, and other professional associations.

House Action

See following Addendum.

Addendum to Resolution 8

Cognitive Services Reimbursement

Alva Louie Mayes, M.D., Delegate
Richard DuBois, M.D., Delegate
Richard Wherry, M.D., Delegate

Our national groups are in support of the Voluntary Fee Freeze which the AMA, MAG, and other specialty societies are supporting.

Please be advised, this Resolution concerning Cognitive Services Reimbursment is completely separate from a fee freeze and has nothing to do with increasing fees, only with the method of payment.

House Action

See House Action for Resolution 10.

Resolution 10

Reimbursement for Supervision of Intravenous Antibiotic Therapy in the Home

Richard DuBois, M.D., Delegate

RESOLVED, that the Medical Association of Georgia convey the need for reimbursement of physicians' services for supervision of home antibiotic therapy to all third party payors in the State of Georgia, including Federal and State government.

House Action

Considered Resolutions 8 and 10 together and adopted the following substitute:

"RESOLVED, that the Medical Association of Georgia support the concept of equitable reimbursement for physicians' cognitive services in comparison to diagnostic and therapeutic services, and be it further

RESOLVED, that there should be no discrimination in reimbursement based on the setting in which the service is rendered, and be it further

RESOLVED, that this resolution be referred to the AMA House of Delegates."

Resolution 11

Advertising of Hospital Services

Harrison L. Rogers, Jr., M.D., Delegate
Medical Association of Atlanta

RESOLVED, that hospitals in Georgia involve their organized medical staffs in the development of statements describing the hospital's medical services, and be it further

RESOLVED, that this Resolution be sent to the AMA House of Delegates.

House Action

Adopted the following substitute resolution:

"RESOLVED, that MAG encourage its members who are on hospital staffs to involve themselves in their hospitals' marketing and advertising endeavors, and be it further

RESOLVED, that this resolution be sent to the AMA House of Delegates."

Resolution 12

Freeze on Physicians' Fees

Richmond County Medical Society

RESOLVED, that the MAG House of Delegates goes on record as favoring a freeze on fees and urges each physician practicing in Georgia to participate in freezing their fees.

House Action

See House Action for Resolution 26.

Resolution 16

Voluntary Freeze on Physician Fees

Muscogee County Medical Society

RESOLVED, that the MAG hereby approves the concept of a one year voluntary freeze on physician fees effective immediately.

House Action

See House Action for Resolution 26.

Resolution 19

Fee Freeze

DeKalb Medical Society

RESOLVED, that members of the Medical Association of Georgia agree to maintain their fees at the current level for 12 months, and be it further

RESOLVED, that MAG members agree to continue to assist all patients — in particular, the uninsured, the unemployed, and the elderly — by taking into account their ability to pay, and to accept reduced fees where necessary, and be it further

RESOLVED, that we instruct our AMA delegates to introduce this or similar resolution to the AMA House of Delegates, and if approved, we urge providers of health care in all disciplines to do likewise.

House Action

See House Action for Resolution 26.

Resolution 20

Fee Freeze

F. William Dowda, M.D., Delegate

RESOLVED, that this MAG House of Delegates endorse the position taken by the AMA Board of Trustees and thereby urge its members to truly freeze their fees for one year and caution them that any pass through attempt or cost shifting attempt would be irresponsible and self defeating.

House Action

See House Action for Resolution 26.

Resolution 22

Hospital Staff Privileges

F. William Dowda, M.D., Delegate

RESOLVED, that the MAG recognize that hospital staff privileges are a right of properly qualified physi-

cians, and seek appropriate legislation to ensure preservation of that right — i.e., open hospital staffs — and that this resolution be sent to the AMA House of Delegates for further discussion and implementation.

House Action

Referred this resolution to an appropriate MAG Committee for consideration and action.

Resolution 24

Endorsement of Indemnity Plans

F. William Dowda, M.D., Delegate

RESOLVED, that indemnity plans are endorsed by the Medical Association of Georgia as being preferable to all others in that it encourages the development of both patient and physician responsibility, trust and mutual respect, and in that the negotiation of the payment of the remainder of the fee (if any) establishes a contract between the patient and doctor which should improve quality of care and patient-doctor understanding, and, be it further

RESOLVED, that this resolution be submitted to the AMA House of Delegates for further discussion and implementation.

House Action

Considered this resolution in conjunction with Section 1 of the Third Party Relations Committee (see page 397) and referred Resolution 24 to an appropriate committee for consideration and action and referred Section 1 of the Third Party Relations Committee to the same appropriate committee for information.

Resolution 26

Health Care Costs

Bibb County Medical Society

RESOLVED, that the MAG propose a voluntary one year freeze on physicians' fees, and be it further

RESOLVED, that the Georgia Hospital Association be requested to propose a voluntary one year freeze on hospital charges to its member hospitals in the State of Georgia.

House Action

Considered all the resolutions on Fee Freezes (#12, 16, 19, 20 & 26) together and adopted the following substitute:

"RESOLVED, that MAG endorse the AMA concept (a) that the physicians voluntarily try to hold the line on fees for a period of one year beginning March 1, 1984, and (b) that each physician continue to take into account the financial circumstances of each of his or her patients in setting fees and to accept reduced fees where appropriate, and be it further

RESOLVED, that MAG communicate these suggestions to all Georgia physicians, as well as the other health care provider groups in Georgia, for their individual consideration."

Resolution 33

Physician Fees

F. W. Dowda, M.D.

RESOLVED, that the MAG endorse the concept that the unit cost of medical care is the same in a particular locality in both the fee for service and prepaid environment, and the differences that are expressed in charges are due to overutilization by the physician or patient or underutilization by the physician or patient and that this problem can be properly addressed by peer review.

House action

Referred to the appropriate MAG committee.



WANTED

Board Certified physicians or finishing residents in the following specialties who desire an attractive alternative to civilian practice:

GENERAL SURGERY
ORTHOPEDIC SURGERY
NEUROSURGERY
OTOLARYNGOLOGY
CHILD PSYCHIATRY
PEDIATRICS
MEDICAL RESEARCH
DIAGNOSTIC RADIOLOGY

Positions are available at both Army teaching facilities and community hospitals throughout the Southeastern United States.

Every Army physician is a commissioned officer. The Army offers a rewarding practice without the burdens of malpractice insurance premiums and other non-medical distractions.

Army medicine provides a reasonable salary while stressing a good clinical practice. Some positions offer teaching appointments in an affiliated status with nearby civilian medical schools or teaching programs. The Army might be just the right prescription for you and your family.

To obtain more information on eligibility, salary, and fringe benefits write or call collect:

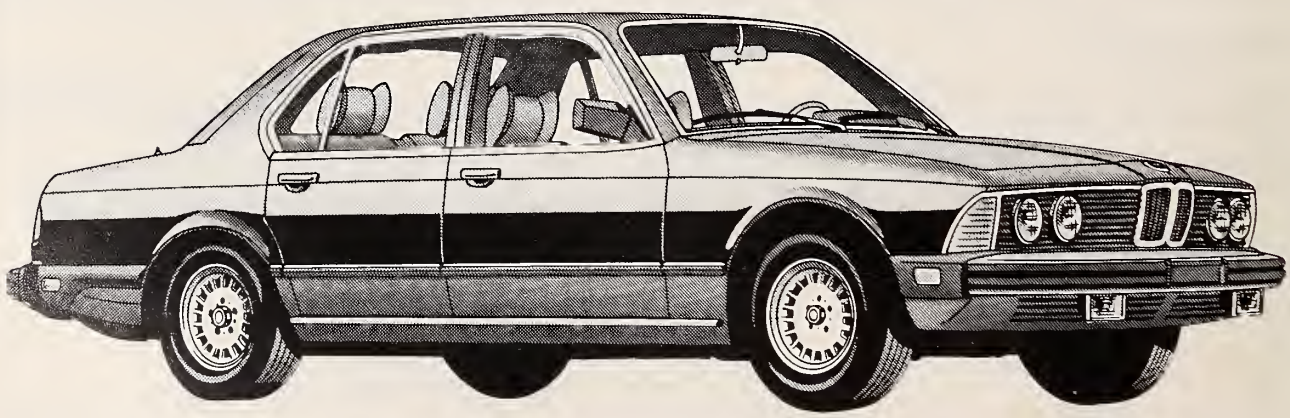
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Report of Reference Committee C

J. Robert Logan, M.D., Savannah, Chairman
Charles A. Lanford, M.D., Macon, Vice Chairman

In addition to the Chairman and Vice Chairman named above, the following persons served on Reference Committee C: S. Boyd Eaton, MD, Decatur; Joseph M. Almand, Jr., MD, LaGrange; E. Van Herrin, MD, Athens; William A. Wolff, MD, Columbus; Ralph Tillman, MD, Decatur; and James L. Askew, MD, Riverdale.

Georgia Medical Political Action Committee — GaMPAC

Beverly B. Sanders, Jr., M.D., Chairman

Your Georgia Medical Political Action Committee has had to establish for itself a new direction and a new charge.

For some unknown reason, the physicians of this state have lost contact with the mechanism that, more so today than in the past, can influence the course of medical care and medical practice: political action, politics and politicians.

The office of every Georgia State Senator, Georgia State Representative, and Georgia U.S. Congressman is up for election every 2 years. And this 1984 is ELECTION YEAR. The costs to get elected have escalated far greater than has the inflation rate. For example, the planning costs for a State House seat in a rural county is $11,000, while the costs for a rural Senate seat runs from $20,000 to $50,000. The estimated costs of a Congressional Race is $300,000 plus.

It doesn't take much calculation to understand that with the races of 56 State Senators, 186 State Representatives, 10 U.S. Congressmen, and the U.S. Senate race of Sam Nunn, it is extremely costly to all interested parties every election year.

The need for physicians, through GaMPAC, to have an active part in who gets elected depends on the total physician membership to GaMPAC. These are the only monies which GaMPAC has to make your contributions.

As of March 1, 1984, for 1984, there are 608 physicians who are sustaining members of GaMPAC. There are 5,500 members of MAG. One has to assume that 89 percent of the MAG members could care less who is elected and who will decide the fate of medical issues before the U.S. Congress, the Georgia Senate, and the Georgia House.

Two Congressional issues that obviously do not concern these 89 percent are:

Medicare Assignment — This proposal which will be voted on in 1984, would *mandate* that as a prerequisite to hospital staff privileges, the physician *shall* take 100% assignment, and if the physician bills the patient for the balance, he will have committed a felony.

In-Patient Services — Legislation is pending which would mandate that there would be only one statement to Medicare or to private pay patients and that statement would be from the hospital and that it would be up to the hospital to pay the surgeon, the internist, and all other physicians who treat the in-patient.

One has to assume that 89 percent of our colleagues want to be employed by the hospitals.

Our 10 Congressmen who are elected this fall will play a vital role in the outcome of those issues and others that will be voted on this year.

On the State scene, we, the physicians of Georgia, through the MAG, are constantly asking our State Senators and State Representatives to support our position and to work with us to mold the outcome of legislation dealing with medical care and medical practice. Issues such as the intrusion into medicine by unqualified para health groups, Certificate of Need, Hospital Staff Privileges, Medicaid Reimbursement, Peer Review Immunity, and our *ever* increasing need to change our tort laws, just to name a few.

We have asked for their help, and they have responded very favorably, and now it is our turn to respond to their needs and to assist them in getting re-elected this year. Without membership in GaMPAC, there would be no monies for organized medicine to contribute — without this, our perpetual opponents would have a much greater opportunity to defeat our friends and elect theirs.

GaMPAC is at the crossroads of being a very viable organization, and this must take place for the salvation of medicine as we know it. In 1982, GaMPAC/AMPAC contributed to candidates in Georgia $168,000, and this was with 725 active physician members in 1982. Let your imagination and your calculator figure out the amount of contribution dollars we could contribute if we had 1,000 or even 2,000 GaMPAC members whose dues are $150 which qualify for the allowable portion as a tax credit on your income tax return.

The GaMPAC Executive Committee plans to submit, to the June meeting of the MAG Board, a slate of Directors for approval or veto by the MAG. It is our hope that the relationship between MAG and GaMPAC remains as close in the future as it is today, for if there ever was two organizations that need each other we definitely qualify.

House Action

Adopted the following Recommendation: That the MAG, through its committees and staff, encourage MAG members to become active members of the Georgia Medical Political Action Committee. It is incumbent upon us as physicians in this state to realize that continued active political involvement will be a necessity for the foreseeable future. The best mechanism by which the physicians of Georgia can participate in this arena is GaMPAC.

Committee on Legislation

James A. Kaufmann, M.D., Chairman

The 1984 legislative session was the shortest session in legislative history. The law mandates 40 working days; however, the session generally runs from early January to



Rupert H. Bramblett, from Cumming, addresses members of the House.

early April. This year they finished before March 1.

Once again, medically related issues dominated by numbers more individual pieces of legislation than all others. I am very proud to state that even with the 120 medically related bills that could have passed the General Assembly that only one bill passed that we had reservations about, and even it was significantly amended to dilute its impact and even postpone its effective date for at least one year and possibly more.

The MAG sought and assisted in the passage of several bills of major concern to the M.D.s in Georgia. The MAG also assisted in the defeat of several bills which, if passed, would have been detrimental to the health and safety of our citizens. One issue was the repeal of the motorcycle helmet law. A list of all major bills is incorporated in this report.

There were only two bills which MAG introduced which did not pass, Senate Bill 329 — Dismissal Clause, but we feel confident this will pass early in the 1985 session, and House Bill 1013 — Workers' Compensation — Selection of Practitioner.

The MAG Physician Involvement Program was again a tremendous success, and the value of our members being at the Capitol on a daily basis is a direct reflection on the success of our overall legislative program. Some 170 physicians participated in the PIP this year and Bibb County, on one day, brought 20 of their members plus spouses to Atlanta to be a part of this program.

The Doctor-of-the-Day program is still the most appreciated program that is provided to members of the General Assembly. For the third year, Ms. Pam Acree was our nurse and did another outstanding job, not only as our nurse, but also in representing you and MAG. This year our aid station, which is now on the second floor, was remodeled and provides us the space and the amenities to provide an even better service to the members of the General Assembly and their staff.

Your Legislative Committee again plans to have a Legislative Seminar, August 24-26, 1984, at the Hyatt on Hilton Head. We again plan to have 10-12 State legislators and approximately 80 MAG members and their spouses in attendance.

In addition to this statewide legislative seminar, we are considering having a similar seminar for just our members in Fulton County. The diversity of Fulton County, the residential location of the M.D.s and the office locations of the M.D.s, coupled with the total number of legislators, 24, from Fulton County make this program almost a necessity to better educate and involve the M.D.s of Fulton County in the legislative process. We are considering seeking support with the Georgia Hospital Association with the hospitals in Fulton County to form this program.

The MAG staff assigned to the area of legislation are to be commended for their dedication to the job. No one knows better than I how much time, from early morning hours to early evening hours every day, it takes to successfully work in the legislative process. I want to thank them personally and hopefully you will do likewise: Ms. Hollie Ross, Mr. Gould Hagler, and Mr. Rusty Kidd, for their tireless efforts.

1984 Legislative Issues of Major Concern

House Bill 49 — Informed Consent
(Passed by substitute) (MAG supported substitute)

After two years of considering numerous drafts, the General Assembly passed a substitute version of H.B. 49 which is acceptable to MAG. The law directs the Composite State Board of Medical Examiners to publish an informational booklet on breast cancer. The Medical Consent Act has not been amended and physicians' legal position regarding informed consent has not changed.

House Bill 602 — Juvenile Proceedings-Parental Rights
(Passed) (Supported)

It specifically establishes in State law, a statute dealing with when a parent has given up parental rights of their child and when the child can be taken from the parents. Provides for confidentiality of information, child placement; establishes mechanism for treatment of child and other circumstances to insure the protection and well-being of the child.

House Bill 723 — Repeal of Motorcycle Helmet Law
(Did not pass) (MAG opposed)

The event I was most proud of during this session, was the defeat of the act to repeal the requirement of motorcycle riders to wear helmets. This bill was being steamrolled for passage when Dr. Bill Moore, your president, and I argued before the final committee about the serious injuries and death this repeal would cause.

Dr. Moore, a neurosurgeon, poignantly stated that if the repeal passed, it would increase his practice 10-15%.

This was another instance where physicians argued against their own interest for the protection of their patients and their loved ones.

Despite a very large group of motorcyclists from over the state and their lobbyists fighting for the repeal of this bill, the committee voted in our favor 3-2.

I feel that I may have saved more lives in this one afternoon of work than I would in a lifetime of practice.

House Bill 901 — Sales Tax — Prescription Drugs
(Passed)

Removes Georgia sales tax on prescription drugs.

House Bill 908 — Conflict of Interest — Seeking Elected Office
(Passed)

House Bill 908 creates an exemption to allow physi-

cians and others accepting Medicaid payments to serve in the General Assembly. (Under present law, the acceptance of Medicaid is considered doing business with the state, and is therefore a prohibited activity for legislators and other state officials.)

House Bill 998 — Child Molestation
(Passed)

Provides that persons convicted of child molestation shall be punished by imprisonment for not less than one nor more than 30 years.

House Bill 1013 — Workers' Compensation — Selection of Practitioner
(Did not pass) (MAG supported)

Would have repealed existing law which requires the employer to pass a panel of practitioners of at least three practitioners from which the employee must choose for their medical needs. House Bill 1013 would have permitted the employee the freedom of choice to choose the practitioner of their choice.

House Bill 1027 — Physician's Assistants Exam
(Passed) (MAG supported)

Requires that PAs take an examination approved by the Composite State Board of Medical Examiners prior to receiving certification by the Board.

House Bill 1057 & House Bill 1058 — Pacemakers
(Passed)

Permits pacemakers to be an anatomical gift and permits the resale of a used pacemaker.

House Bill 1068 — County Boards of Health — Membership
(Passed)

Requires that each County Board of Health be composed of seven members: the chief executive officer of the governing authority of the County, the County Superintendent of schools, a physician in active practice or if none will serve a nurse or dentist, a consumer from the largest municipality in the county, and a consumer to represent the county's needy. House Bill 1068 establishes terms of office, sets guidelines for rules, responsibility of authority, establishes fees, etc.

House Bill 1133 — Dietitians
(Passed)

Creates a licensure board for dietitians, who if they meet the qualifications of the Board, could call themselves L.D. or Licensed Dietitians.

House Bill 1162 & House Bill 57 — Chiropractic Scope of Practice
(Did not pass)

Both bills would have greatly expanded the scope of practice for chiropractic services.

House Bill 1181 — Foreign Medical Graduates
(Passed)

Requires that all future applicants to the Composite State Board of Medical Examiners desiring to take the Flex Exam, in order to hold an active license to practice medicine in Georgia, must first be a graduate of a school approved by the Board. Prior to this law the Board had no specific authority to approve or disapprove of offshore medical schools.

House Bill 1230 — Jury Excuses
(Passed)

Repeals the law which gives blanket jury exemption from ever serving on a jury. These persons were physicians, dentists, firemen, lawyers, school teachers, railroad workers, policemen. House Bill 1230 enables all persons to serve jury duty; however, it does provide the judge the authority to grant exemptions.

House Bill 1276 — Peer Review — Immunity
(Passed) (supported)

This bill closes loopholes in the law which grants immunity to peer review organizations and which makes the proceedings of peer review committees confidential. House Bill 1276 will protect the integrity of the peer review process by making certain that peer review records are not subject to discovery in lawsuits. The bill also extends coverage to underwriting committees of professional liability insurance companies such as MAG Mutual.

House Bill 1296 — Indigent Care Act
(Passed)

House Bill 1296 would require hospitals to treat women in "active labor" without regard to their ability to pay. Hospitals are covered under the law if they usually and customarily provide obstetrical services. Physicians and hospitals are immune from liability except in cases of gross negligence. If, in the judgment of the physician, the hospital is unable to provide appropriate treatment, the hospital must arrange for transfer to another hospital. The county of residence of the patient is responsible for payment to the hospital and the physician.

House Bill 1468 — Non-Medical Health Care Practitioners Act
(Did not pass)

Would have established a new state licensure board to license all persons who claim to treat patients who are not already licensed. This would include naturopaths, massage therapists, vitamin therapists, foot reflexologists, hair analysts, etc.

House Resolution 443 — Radiation Health & Safety Study Committee
(Passed)

In lieu of legislation requiring the licensure of all persons using X-ray machines, this resolution passed creating a study committee to study radiation health and safety.

House Resolution 708 — Indigent Care Study Committee
(Passed)

This resolution creates a joint legislative study committee to study indigent care in Georgia along with how and where indigents can be treated. A recommendation of this committee will be presented to the 1985 General Assembly.

Senate Bills

Senate Bill 93 — Licensure of Social Workers, Marriage and Family Therapists, and Professional Counselors
(Passed)

Senate Bill 93 creates a state licensing board for members of these professions. However, the law will not take effect until money is appropriated to fund the establishment of the board.

Senate Bill 186 — Living Will
(Passed)

Senate Bill 186 creates in law a so-called "Living Will," a written directive executed by a person stating his desire that life-sustaining procedures be ceased when he is in a terminal condition and death is imminent.

Punitive action against physicians has been removed from the bill.

Senate Bill 374 — Disabled Adults Protection Act
(Passed)

Requires that any person who has reasonable cause to believe that a disabled adult is in need of protective services shall report such information.

Senate Bill 401 — Patient Records
(Passed)

This bill gives the patient easier access to the physician's record of treatment. Upon written request from the patient, the physician must provide copies of the records. The physician may charge a fee to cover the cost of reproduction. If, in the opinion of the physician, disclosure of the records will be detrimental to the mental or physical health of the patient, the physician may furnish the records to another physician designated by the patient.

There were obviously too many medically related bills that were of interest to MAG to report on in this report, however, if you know of one and would like information on it or additional information or a copy of any of the issues mentioned in this report, please contact the Legislative Department of your MAG.

House Action

Filed with commendation.

Occupational Health Committee

Robert P. Cunningham, M.D., Chairman

The Occupational Health Committee held one meeting in the past year. The Committee discussed two issues and made recommendations on each subject.

Medical Board to the Workers' Compensation Board

The Medical Board of the State Board of Workers' Compensation is established by Georgia law "to hear and determine controversial medical questions in claims for compensation arising in cases of death or disability from occupational disease." [Code Section 34-9-310 (a)] The law specifies that the Governor shall select as the Board's five members licensed physicians expert in internal medicine, roentgenology, chest disease, pathology, dermatology, and toxicology.

The Medical Board is more than an advisory board. "In the area of occupational disease, controversial issues of medical facts are to be determined by the medical board and its findings and report . . . shall be accepted by the State Board of Workers' Compensation as conclusive upon the medical question therein decided." (34-9-310 note)

Upon investigation, the Committee found that the terms of all the members of the Medical Board have expired, and all the members are serving until replaced by the Governor. Furthermore, some of the specialties represented on the board are not in accord with the specialties provided for in the law. (There are two general surgeons and an obstetrician on the board.)

A properly constituted and effective Medical Board is essential to the functioning of the Workers' Compensation system. Occupational disease — particularly disease of the chest — is becoming a larger and larger share of Workers' Compensation claims. The amounts of money involved are growing in significance. The need for sound medical opinion is critical.

The Committee therefore recommended a new slate of names for the Medical Board. The list has been approved by the MAG Executive Committee and submitted to the Governor.

"Panel of Three" Physicians

In 1983, the House of Delegates adopted Resolution 12 calling for MAG to seek legislative repeal of the provision of the Workers' Compensation law which allows the employer to limit the injured employee's choice of physicians. (The law requires the employer to post a panel of at least three physicians for the employee to choose from.) At the request of MAG, a bill was introduced in the 1984 Georgia General Assembly to allow the employee to seek care from any physician of his choice. The bill failed.

The Committee believes that the policy adopted in 1983 is unwise and, for the reasons set forth below, supports the current law which requires the employer to post a panel of at least three physicians.

First, the unique aspects of the Workers' Compensation system justify the employer's exercising some degree of control over the employee's access to health care. Compensation insurance is not analogous to a fringe benefit, such as a health insurance policy. It is rather a mandatory program established by the state to protect the employee. Workers' Compensation insurance pays if the injury or disease occurs in the course of employment without regard to whether the fault lies with the employer, the injured employee, or a co-worker.

Second, it is not accurate to say that the present law assumes that physicians are dishonest and would help employees "milk" the system. The "panel of three" provision, rather, is an expression of the necessity for the employer to select physicians most expert in occupational injury and disease in general, and also in those particular diseases and injuries most likely to occur in the employer's particular industry. The argument that the physician chosen by the company has only the company's interests in mind is fallacious. An ethical physician would not say a sick man is able to return to work, nor would he allow a well employee to remain off the job.

Thirdly, it is important to keep in mind that "physician," as defined by the Workers' Compensation law, encompasses any person licensed to practice any healing art in Georgia. The legislation introduced in the 1983 session, and any other bill drafted to implement Resolution 12, would permit the employee freedom of choice to choose a limited licensed practitioner as well as an M.D.

Finally, further pursuit of the policy adopted in 1983 would adversely affect MAG's relations with the business community. Medicine and business must work together in efforts to make medical care more cost efficient. Opposing business in Workers' Compensation would do damage to our common efforts, particularly in the area of medical



Delegates from Georgia Medical Society in Savannah include MAG's Past President, Dr. Carson B. Burgstiner (on the second row).



(L to R) Drs. H. Duane Blair, John P. Heard, and Charles W. McDowell, Jr., are delegates from DeKalb Medical Society in Decatur.

malpractice tort reform.

Recommendation

For the reasons outlined above, the Committee recommends that MAG repeal the policy on "Workers' Compensation Freedom of Choice" adopted in 1983, and discontinue its legislative effort to amend the "panel of three" provision.

House Action

Adopted the recommendation amended as follows:

"For the reasons outlined above, the Committee recommends that MAG repeal the policy on "Workers' Compensation Freedom of Choice" adopted in 1983. And that it discontinue its legislative effort to amend the "panel of three" provision, and direct its component county medical societies to work with their business coalitions to inform them of the existing law which directs the employer to post a panel of three or more providers."

Resolution 9

Medical Staff Privileges

W. Daniel Jordan, M.D., Delegate

RESOLVED, that the Medical Association of Georgia House of Delegates oppose legislation that would require hospitals to require physicians to accept Medicare assignment as a condition of medical staff membership.

House Action

Adopted.

Resolution 13

Mandatory Fee Assignment

W. Daniel Jordan, M.D., Delegate

RESOLVED, that the Medical Association of Georgia House of Delegates oppose legislation requiring mandatory assignment of physicians' fees, and communicate this opposition to the Georgia Congressional delegation and to the American Medical Association House of Delegates.

House Action

Adopted.

Resolution 18

Professional Liability Tort Reform

DeKalb Medical Society

RESOLVED, that the MAG Legislative Committee be charged with the task of developing a reasonable tort reform package to be introduced in the 1985 session of the General Assembly, and be it further

RESOLVED, that the Public Relations Committee of the Medical Association of Georgia be charged with the task of promoting the importance of these tort reform changes and work with the Georgia Hospital Association, health care coalitions, and others in a manner to assure successful passage and implementation of this legislation.

House Action

Adopted.

Resolution 21

Participating Physicians' Plans and Preferred Provider Organizations

F. William Dowda, M.D., Delegate

RESOLVED, that the MAG seek immediate legislative relief both from state and federal statutes which prevent medical societies from passing judgment on the appropriateness of fees of their members (both too high and too low) and the appropriateness of services (either unnecessary or inadequate) rendered by their members, and be it further

RESOLVED, that the MAG seek the same levels of immediate legislative relief which would permit the medical society to serve as a bargaining agent with the PPPs and PPOs which would permit the society not to set individual physicians' fees but to deal with the fairness of the percentile level and to deal with an appropriate fee adjustment each year to deal with inflation, and be it further

RESOLVED, that further legislative relief be sought which would permit a medical society to intercede for one of its members which had been excluded from a PPP and PPO and along the same line that the requirements of performance for entering and maintaining membership in a PPP and PPO must be clearly stated by the PPP or PPO

and that this clear statement be mandated by law so that the PPP or PPO could not be used to restrain trade and reduce competition, and be it further

RESOLVED, that the MAG seek amendments to the insurance code which would require the carriers to pay a non PPP or PPO physician no less than is paid to a PPO or PPP physician for the same service and that if the PPP or the PPO permits assignment that the non PPP or PPO physician must be accorded the same privilege and this resolution be sent to the AMA House of Delegates for further deliberation and implementation on cost containment.

House Action

Adopted the following substitute Resolve:

RESOLVED, that MAG ask AMA to seek immediate legislative relief from the anti-trust laws that prevent medical societies from passing judgment on the appropriateness of services and fees rendered by their members and from properly representing and negotiating for its members and that this Resolution be sent to the AMA House of Delegates for further deliberation and implementation.

Resolution 23

Cost Containment

F. William Dowda, M.D., Delegate

RESOLVED, that the MAG seek immediate legislative relief which would permit it to review physicians' fees for appropriateness and physicians' services (personal, lab, and hospital) for appropriateness wherever they occur: With the knowledge that this review will return the emphasis to the proper place, i.e., quality instead of cost — while at the same time offering an opportunity for *rational* cost savings, and be it further

RESOLVED, that this resolution be sent to the AMA House of Delegates for further deliberation and implementation there.

House Action

Adopted.

Resolution 27

Composite State Board of Medical Examiners Rules and Laws Information

Georgia Medical Society

RESOLVED, that the Medical Association of Georgia request the Composite State Board of Medical Examiners to furnish each member of the Medical Association of Georgia a copy of the "Rules" and "Laws" of the Board, and be it further

RESOLVED, that the Editor of *JMAG* consider publishing in the *Journal of the Medical Association of Georgia* the newsletter of the Composite State Board of Medical Examiners or excerpts therefrom on a regular basis.

House Action

Adopted the first Resolve with the addition of the words "on request" so that it would read as follows:



Drs. Charles D. Hollis, Jr., and S. William Clark, Jr., at the head table of House of Delegates.

"RESOLVED, that the Medical Association of Georgia request the Composite State Board of Medical Examiners to furnish on request to each member of the Medical Association of Georgia a copy of the "Rules" and "Laws" of the Board.

Adopted the second Resolve as is.

Resolution 29

Recommendations to SHPDC

S. Boyd Eaton, M.D.

RESOLVED, that the appropriate committee of MAG develop recommendations for a Health Promotion and Disease Prevention Program and that MAG communicate these to the State Health Plan Development Committee so that this committee will have meaningful input from the practicing physicians of Georgia.

House Action

Adopted.

Resolution 30

Statute of Limitations

Medical Association of Atlanta

RESOLVED, that MAG seek to have legislation introduced in the Georgia General Assembly to revise the statute of limitations for perinatal occurrences so as to allow action to be brought until two (2) years after the plaintiff's sixth birthday.

House Action

Adopted the following substitute Resolve:

RESOLVED, that the MAG seek to have legislation introduced in the Georgia General Assembly to revise the statute of limitations for medical malpractice as follows:

> "The current limitation of occurrence plus two (2) years for adults be extended to apply to minors greater than or equal to six (6) years of age at the time of occurrence.
>
> "If, at the time of occurrence, the alleged injured is less than six (6) years of age, action could be brought until two (2) years after the plaintiff's sixth birthday."

Resolution 31

Memorializing Lawrence P. McDonald, M.D.

Medical Association of Atlanta

RESOLVED, that the MAG House of Delegates in annual session in April, 1984, express its horror and indignation at the murder of our colleague, Lawrence P. McDonald, M.D., by Soviets, and be it further

RESOLVED, that the MAG House of Delegates ask the President of the United States to demand apology and reparations for this brutal act, and be it further

RESOLVED, that the MAG House of Delegates express its sympathy to his widow, Mrs. Kathryn McDonald, his mother, Mrs. H. P. McDonald, Sr., and to his children by means of this resolution, and be it further

RESOLVED, that the MAG House of Delegates express its profound commendation to the memory of Lawrence P. McDonald, M.D., for his understanding of and dedication to the causes of medical freedom in the United States.

House Action

Did not adopt second Resolve. Amended the third Resolve to include "and to his brother Harold P. McDonald, Jr., M.D." among those to whom sympathy is expressed. Adopted the other Resolves as written.



Jack A. Raines, M.D., Columbus, served as Parliamentarian of the House of Delegates.

Resolution 32

Generic Drug Substitution

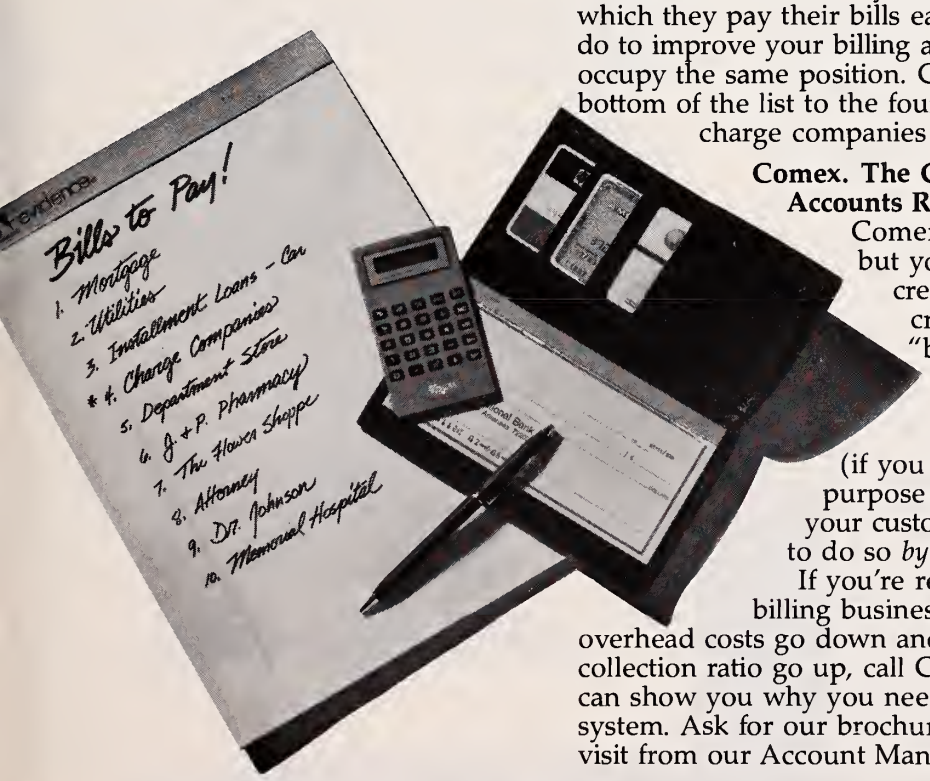
F. W. Dowda, M.D.

RESOLVED, that the MAG seek amendment of the drug generic substitution law so that the physician would be exempt from the liability of product failure.

House Action

Adopted.

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Let's face it. Telling a patient his stomach problems, liver disorders, etc., are alcohol related is not easy. Handle it wrong and you not only could lose a patient, you could make an enemy.

Charter By-the-Sea Hospital on St. Simons Island can help. They'll work confidentially with you, the patient's family, or the patient himself to assess the problem. If hospitalization is necessary, Charter By-the-Sea will keep you informed of the patient's progress and return him to your care upon discharge.

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Charter By-the-Sea also has a comprehensive mental health unit for short-term inpatient treatment of a full range of psychiatric disorders. The resources of this unit are available to drug and alcohol patients if necessary.

And because the hospital is JCAH accredited and fully licensed, most major hospitalization insurance plans cover treatment.

If you have a patient who may need help for drug or alcohol abuse, call toll free. A physician is available 24 hours to take your call.

Charter By-the-Sea

St. Simons Island, Georgia

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Report of Reference Committee D

William R. Hardcastle, M.D., Decatur, Chairman
Philip Z. Israel, M.D., Marietta, Vice Chairman



William R. Hardcastle, Decatur, served as Chairman of Reference Committee D.

In addition to the Chairman and Vice Chairman named above, the following persons served on Reference Committee D: William Whaley, MD, Atlanta; Robert B. Quattlebaum, Jr., MD, Savannah; Alva Louie Mayes, Jr., MD, Macon; Joel Todino, MD, Rome; A. Delone Muse, Jr., MD, Athens; and Carey W. Goodman, Jr., MD, Statesboro.

Committee on Education

Victor A. Moore, M.D., Chairman

During the past year, the Committee has met twice and continues to fulfill its various responsibilities. Much of our work is conducted through our Subcommittees on Accreditation, Health Education, Hospital CME, and Medical Schools. Our activities may therefore be reported best under these headings:

Accreditation — The Education Committee, through its Subcommittee on Accreditation (James Maughon, MD, Chairman) continues to conduct the very important responsibility of accrediting hospital and specialty societies within Georgia for their programs of continuing medical education (CME). Currently the following CME providers have received accreditation through the MAG:

American Academy of Pediatrics, Georgia Chapter
American Cancer Society, Georgia Division
Americus/Sumter County Hospital
Athens General Hospital/St. Mary's Hospital, Athens
Atlanta Society of Pathologists
DeKalb General Hospital, Decatur
Georgia Academy of Family Physicians
Georgia Academy of Family Physicians Educational Foundation
Georgia Baptist Medical Center, Atlanta
Georgia Gastroenterologic Society
Georgia Affiliate, American Heart Association
Georgia Orthopaedic Society
Georgia Psychiatric Association
Georgia Radiological Society
Georgia Rheumatism Society
Georgia Society of Anesthesiologists
Georgia Society of Ophthalmology
Georgia Surgical Society
Greater Atlanta Otolaryngology — Head and Neck Surgery Society
John D. Archbold Memorial Hospital, Thomasville
The Medical Center, Columbus
Medical Center of Central Georgia, Macon
Memorial Medical Center, Savannah
Metropolitan Hospital, Atlanta
Northeast Georgia Medical Center, Gainesville
Northside Hospital, Atlanta
Phoebe Putney Memorial Hospital, Albany
Piedmont Hospital, Atlanta
Scottish Rite Hospital, Atlanta
South Fulton Hospital, East Point
Southeastern Angiographic Society
St. Joseph's Hospital, Atlanta
Tanner Memorial Hospital, Carrollton
University Hospital, Augusta
VA Medical Center, Dublin
West Paces Ferry Hospital, Atlanta

The above institutions have each been surveyed (and most resurveyed) by a site visit team from the Committee, which continues to receive applications from hospitals and specialty societies desiring accredited status.

Health Education — The principal achievement of this subcommittee, chaired by Dr. Tom Wade of Columbus, was the holding last November 10 of an MAG seminar, "Current Trends in Health Education," at the Dunfey Hotel in Atlanta. We attracted over sixty health education professionals to hear what's happening in Georgia's programs of health education in schools, hospitals, the public sector, and the workplace. As our keynote speaker we brought from New York Mr. Clarence E. Pearson, President and Chief Executive Officer of the National Center for Health Education. We owe a special word of thanks to Dr. Nicholas E. Davies of Atlanta for his help in contacting Mr. Pearson.

The Conference led to great PR for the MAG, and is serving as a first step toward the organization of a statewide network of health educators.

Hospital Continuing Medical Education — Under the chairmanship of Dr. Carl Rosengart of Savannah, this Subcommittee helped organize a conference last October 12 at the Academy of Medicine in Atlanta, explaining the "nuts and bolts" of CME accreditation. We brought together an array of talented speakers. Frances Maitland came from Chicago to talk about the Accreditation Council for Continuing Medical Education (ACCME) and its "Essentials" for Category I CME programs. Dr. Jim Maughon spoke on MAG's procedures for accrediting hospitals and specialty societies; Dr. John Hudson of Macon explained our CME cosponsorship policy. Dr. Rosengart and Dr. Rodney Smith of Gainesville gave advice on how hospitals could strengthen their programs of medical education. An added attraction was a panel of

representatives from Georgia's four medical schools, reporting on their respective activities in CME.

Our conference has led a number of hospitals across the state to request our help in building stronger CME programs, and we are offering our consultation and assistance to them.

Medical Schools — From this Subcommittee came the idea to have a conference dealing with the subject of how Georgia's medical schools are training their graduates for an increasingly competitive and difficult practice setting. Last year's House of Delegates approved the plan, and we included the program in the MAG Leadership Conference, held last January in Atlanta. Thus addressing the subject of "Training Future Physicians for the Competitive Medical Marketplace" were Donald O. Nutter, MD (Executive Associate Dean of Emory), Terrence T. Kuske, MD (Associate Dean for Curriculum of MCG), Louis W. Sullivan, MD (President and Dean of Morehouse), and William P. Bristol, MD (Dean of Mercer).

In addition, Mr. Paul Schwab from Washington gave us an update on GMENAC, and Dr. Harold McPheeters of the Southern Regional Education Board spoke on physician "oversupply" in the South. Finally, Dr. Harry O'Rear told how the Georgia Board of Regents is addressing the issues of medical education and cost and physician supply. We thank all of these speakers, and commend especially Dr. McPheeters, a member of the Education Committee, for his guidance in arranging the program.

ACCME Resurvey of the MAG — One of our principal achievements this year was earning a six-year reaccreditation of the Medical Association of Georgia as a provider of continuing medical education. This means that the MAG will continue to be able to award Category I AMA credit to programs in our annual Scientific Assembly, to our Leadership Conference, Risk Management and other seminars, as well as to other educational conferences which we cosponsor.

The AMA had previously granted accreditation to us in 1980 for a period of four years. We were summoned by the ACCME (which has replaced the AMA as national accreditor) to explain our Scientific Assembly and how we grant Category I credit to CME meetings in Georgia. Accordingly, representatives of the MAG (myself and an MAG staff member) were interviewed in San Diego on January 19, 1984, by ACCME resurveyors. We successfully explained our procedures, and our six years' reaccreditation has resulted.

INTRAV — For some years the MAG has cosponsored with the Medical Association of Atlanta various international travel excursions containing CME seminars planned by INTRAV, Inc. Through phone calls from MAG members, we have become aware that physicians tend to assume that the MAG vouches for the quality of the CME seminar, when in fact we haven't been involved at all in its preparation. Moreover, we have no way of making sure the seminar, held abroad, meets the ACCME "Essentials," which we are obligated to uphold in our educational programs.

Last year we let INTRAV know our reservations, but we still have been given no means of reviewing CME programs prior to their publication. We have also been informed by other state medical associations that INTRAV CME programs do not meet our "Essentials."

We wish to emphasize that our concern is not with the Medical Association of Atlanta, which has been given as little say in the INTRAV CME programs as we. While the Committee is sensitive to the issue of inter-association relationships, we do not feel that departing from established educational standards — those which we require of hospitals and other organizations within the state — is a desirable policy. We therefore recommend that the MAG withdraw its cosponsorship of the MAA-MAG INTRAV programs.

This summary indicates the major areas of activity in which the Committee on Education is engaged. It certainly does not recapitulate all the wide-ranging concerns and endeavors of the Committee, but suggests that we are hard at work in facilitating medical education in Georgia, and that we will continue in our efforts.

As Chairman I would like to thank the members of the Committee for their support and involvement:

Ralph E. Berggren, Macon
Edwin C. Evans, Atlanta
Frank L. Ferrier, Columbus
Glen E. Garrison, Augusta
T. Schley Gatewood, Jr., Americus
John A. Harrel, Jr., Decatur
J. Rhodes Haverty, Atlanta
John A. Hudson, Macon
Thomas D. Johnson, Albany
Robert M. Kolodner, Decatur
John H. McFarland, Columbus
LaMar S. McGinnis, Jr., Decatur
Harold L. McPheeters, Atlanta
James S. Maughon, Atlanta
Hillary R. Newland, Athens
Neil G. Perkinson, Atlanta
Carl L. Rosengart, Savannah
George Shannon, Columbus
Barry D. Silverman, Atlanta
Rodney L. Smith, Gainesville
Roland S. Summers, Savannah
Thomas A. Wade, Jr., Columbus
Kenneth Walker, Atlanta
William C. Waters, III, Atlanta
Ms. Karolyn Kramer, MCG School of Medicine
Mr. Leon Dent, Morehouse School of Medicine
Ms. Susan Middleton, Emory University School of Medicine
Mr. Brent Box, Mercer University School of Medicine
Mrs. Dent W. Purcell (Auxiliary), Savannah

Recommendation

That the Medical Association of Georgia withdraw its cosponsorship of the MAA-MAG INTRAV programs.

House Action

Adopted an amended recommendation to read as follows: "That the Medical Association of Georgia shall continue its cosponsorship of the MAA-MAG INTRAV excursions provided the Education Committee has the opportunity for significant input and prior approval of the scientific program."

Liaison With Medical Assistants Committee

Alvin Clair, M.D., Chairman

This committee serves as the formal means by which the MAG recognizes the Georgia State Society, American



Dr. Milton Johnson from Macon waits his turn to speak at the House. Also shown are Drs. Milton Frank, F. William Dowda, Luther Thomas, Harold Harrison, Bleakley Chandler, William Biggers, Sammie Dixon, Jeffrey Nugent, Dent Purcell, Roland Summers, and James O'Quinn; can you locate them?

Association of Medical Assistants. It serves to promote cooperation between physicians and medical assistants, and to inform MAG members of the activities of medical assistants and whenever feasible to assist in those activities.

With these goals in mind, members of this committee attended the Annual meeting of the GSS-AAMA held at the Savannah Inn and Country Club April 14-17, 1983. At that meeting, as part of the educational program Dr. Alvin Clair, Chairman of this committee, gave a three (3) hour program on "Common Dermatologic Problems."

Members of this committee also attended the educational seminar held in Albany, Georgia, September 23-25, 1983. The Risk Management program entitled "Trials and Tribulations" was organized by the GSS Education and Certification Committee Chairman Pat Cannon, RN, with the cooperation and assistance of MAG Mutual Insurance Company, MAG, and other GSS members. This program was attended by 251 people and was a great success. Future similar risk management seminars are being planned under similar auspices regionally throughout the state as a cooperative effort between the GSS-AAMA, MAG Mutual, and MAG.

We were also in attendance at the GSS Leadership Workshop held in Perry, Georgia, January 14, 1984.

Certification was conferred on a number of members of the GSS during the past year. This certification results from passing examinations given nationally by the American Association of Medical Assistants, Inc. Certifying Board.

One new chapter of the GSS-AAMA was formed during the past year (Gwinnett County Chapter in Snellville). Members of this committee were in attendance and spoke to the medical assistants at their orientation meeting.

Total membership in GSS-AAMA for 1983 stands at 376.

Members of this committee plan to attend the Silver Anniversary Meeting in Columbus, Georgia, in April 1984.

We will also be attending the Educational Workshop in September, 1984, and the Leadership Workshop in Perry in January, 1985.

As Chairman, I would like to thank the members of this Committee for their support:

Sidney Bell, M.D., Rome
Van C. Knowles, M.D., Albany
Minor Vernon, M.D., Macon

Supplemental Report
Committee on Liaison With Medical Assistants

Alvin H. Clair, M.D., Chairman

Since the writing of my original report (see previous report above), I have attended the annual convention of the Georgia State Society, American Association of Medical Assistants. As part of the convention program was an intensive session on risk management featuring a "mock trial" of medical assistants with plaintiff's and defendant's attorneys. This session was highly successful, and it has helped convince MAG Mutual Insurance Company that it should commit its resources to educating medical assistants on their role in preventing professional liability claims. As a result, MAG Mutual and the GSS-AAMA have planned a series of Risk Management Seminars across the state, beginning next month in Rome and ending next January in Atlanta.

I believe strongly that the Medical Association of Georgia, especially through its county societies, should support these seminars. As physicians, we will benefit when our employees become educated in risk management. MAG Mutual has recognized these benefits, and now I believe the Medical Association of Georgia should also. For this reason, we have made the following recommendation.

Recommendation

The Medical Association of Georgia, recognizing the role of medical assistants in preventing professional liability claims, should urge its component county societies to assist the MAG Mutual Insurance Company and the Georgia State Society-American Association of Medical Assistants in their 1984-85 series of Risk Man-



(L to R) Past President H. Hilt Hammett, Jr., and J. R. Turner, both from LaGrange, are delegates from Troup County.

agement Seminars for Medical Assistants. Specifically, county medical societies should assist in publicity among their memberships and encourage their members' employees to attend.

House Action

Adopted with commendation.

Committee on Medicine and Human Values

William Weston, III, M.D., Chairman

The Committee has met twice during the year. We have continued to keep informed on events pertaining to hospice and the Living Will. We also initiated a new project to educate the public on legislation requiring use of child restraint seats in automobiles.

Hospice — This year, federal and state regulations on hospice have been approved. In Georgia, hospices are in the process of being certified and to date about a dozen have received certification.

We continue to believe that the public needs to know more about hospice; and we also think physicians will benefit from information about it, too, especially on the details of Medicare reimbursement. We think that the Auxiliary to the MAG has proven itself especially adept in such public information projects, so our committee has resolved to call upon the Auxiliary for assistance in the coming year.

Living Will — S.B. 1086 has been enacted into law by the Georgia General Assembly, thereby giving official sanction to Living Wills and defining conditions under which they may be used.

Child Restraint Seats in Automobiles — A Georgia law will take effect on July 1, directing parents to have their children under four years of age strapped into automobile child restraint seats while the car is in motion. Statistics have shown that if such a law is obeyed, 90% of children's fatalities in automobile accidents will be prevented.

The Committee has therefore begun to work with the MAG Committee on Public Relations and the Georgia Sheriff's Association in a billboard campaign to educate the public on the law. We have selected an effective billboard design and are having it printed and distributed on billboards throughout the state. We believe that our message will appear on 125-150 billboards during May and June. We gratefully acknowledge the assistance of Turner Outdoor Advertising, Inc., in printing our billboards; we also appreciate the donation of public service space by some two dozen billboard companies in Georgia. Because of these donations, the entire cost of the project to MAG is $3,000, which was contributed by the MAG PR Committee.

Abortion — Our Committee wishes to investigate this issue and to prepare a formal statement regarding the physicians' responsibility in addressing both the patient's welfare and the sanctity of human life. We find that the MAG has taken no philosophic position on abortion. To date, our Executive Committee has stated that physicians must have the right to refuse to perform abortions for any reason (1971), and it also resolved that abortions should be performed only by qualified medical doctors (1973). Our House of Delegates in 1978 supported a recommendation that state funds be made available for abortions.

We think that the MAG should have a more comprehensive statement on this issue, one which should be submitted to the Board of Directors and/or the House of Delegates next year. We therefore ask approval of our resolution to this effect.

As Chairman, I wish to thank the members of the Committee for their support and involvement throughout the year:

Mary Ann T. Hagler, M.D. — Augusta
Gary N. Harrison, M.D. — Statesboro
Frederic K. Kratina, M.D. — LaGrange
Walker C. McGraw, M.D. — Norcross
Hans J. Peters, M.D. — Columbus
Dent Purcell, M.D. — Savannah
Richard B. Stewart, M.D. — Decatur
Caroline J. Williams, M.D. — Savannah
Mrs. W. Jack Smith — St. Simons Island

Recommendations

1. The MAG Auxiliary shall work with the MAG Committee on Medicine and Human Values to develop and implement a means of educating both the public and the medical community about hospice.
2. The MAG Committee on Medicine and Human Values shall investigate the issue of abortion and prepare a position statement that addresses the physician's responsibility both for the welfare of the patient and the sanctity of human life. The statement shall be submitted to the Board of Directors and/or the House of Delegates for its approval during 1985.

House Action

Adopted Recommendation 1.
Did not adopt Recommendation 2.

Committee on Scientific Assembly

Ellis B. Keener, M.D., Chairman

Last November 18-20, the MAG again held its annual Scientific Assembly. Fifteen state specialty societies conducted medical education programs throughout the weekend, and they attracted over 700 physicians to the

Colony Square Hotel in Atlanta. A glance at the weekend suggests the variety of scientific sessions. Highlighting Friday was "Topics in Critical Care," which drew chest physicians, surgeons, and gastroenterologists. The Georgia Rheumatism Society, in cooperation with Syntex Laboratories, held a half-day session on "Managing the Arthritic Patient." Also meeting were allergists, otolaryngologists, and pediatricians.

One of the benefits of the society meetings is their rich blend of guest faculty presentations and state society members' papers. The Georgia Chapter, American College of Surgeons and Georgia Society of Ophthalmology, for instance, devoted Saturday to members' papers. The Emergency Medicine meeting included a unique "hands-on" demonstration of techniques in plastic wound management. Other meetings on Saturday featured lectures for pulmonary critical care, neurology, neurosurgery, pathology, pediatrics, plastic surgery, and psychiatry.

On Sunday morning, November 20, the Atlanta Society of Pathologists held its annual slide seminar with Dr. Robert Collins of Vanderbilt speaking on "The Pathology of AIDS." The Georgia Neurosurgical Society also held a session devoted to socioeconomic issues.

Social functions were part of the weekend, too, as several societies held luncheons and receptions. As part of their luncheon on Saturday, ophthalmologists got a chance to preview the new exhibit on "Sensations" at the High Museum of Art. The Medical College of Georgia alumni also gathered at the Cherokee Country Club, while the Georgia Chapter, American Academy of Pediatrics held a "legislative" reception near the Capitol.

As in every Scientific Assembly, the MAG relies on participating state specialty societies and their program chairmen to select speakers and topics for their colleagues. For our 1983 meeting, we owe a great deal of thanks to the following physicians who arranged programs for their specialties:

David D. Tanner, M.D.
Allergy & Immunology Society of Georgia

Jonne Walter, M.D.
Georgia Thoracic Society

Walter S. Dunbar, M.D.
Ga. Chapter, American College of Chest Physicians

Gail Anderson, M.D.
Ga. Chapter, American College of Emergency Physicians

Paul R. Rodzewicz, M.D.
Georgia Gastroenterological Society

Mark Kozinn, M.D.
Georgia Neurological Society

Robert E. Dicks, III, M.D.
Georgia Neurosurgical Society

David Campbell, M.D.
Georgia Society of Ophthalmology

William E. Silver, M.D.
Albert A. Clairmont, M.D.
Georgia Society of Otolaryngology — Head and Neck Surgery

Russell K. Brynes, M.D.
Georgia Association of Pathologists

Jerry D. Porter, M.D.
Atlanta Society of Pathologists

George Brumley, M.D.
Ga. Chapter, American Academy of Pediatrics

Robert Zaworski, M.D.
Georgia Society of Plastic Surgeons

Donald Manning, M.D.
Georgia Psychiatric Association

Sanford S. Hartman, M.D.
Georgia Rheumatism Society

Eugene D. Davidson, M.D.
Ga. Chapter, American College of Surgeons

The MAG assists participating societies by handling hotel arrangements, publicity, coffee breaks, audiovisual equipment, and registration. From the registration fees received, the Association reimburses societies for their speakers' expenses. These operations are supervised by the MAG Scientific Assembly Committee.

Plans for the 1984 Scientific Assembly are already underway. It will be held during November 16-18 at the Ritz-Carlton Buckhead Hotel in Atlanta, across from Lenox Square and Phipps Plaza.

This fall's meeting will be our Tenth Annual MAG Scientific Assembly, and we think it is time for us to evaluate our meeting and to determine its strengths and weaknesses. Generally speaking, we find that most state specialty societies do not object to the MAG serving as "umbrella" for a concurrent gathering of the specialties, especially when the MAG staff handles hotel arrangements, publicity, etc.

Yet there are problems, too. The high cost of securing good speakers threatens some of the smaller societies with the probability of financial loss if they should participate in the Scientific Assembly. And the demand for nationally known guest speakers has made it increasingly difficult for specialty program chairmen to arrange first-rate agendas at their meetings. Finally, the growing competition among CME sponsors — medical schools, national and state specialty societies, and hospitals — has created the prospect of dwindling attendance while costs and other problems mount annually. In 1980, for the first time in the history of the Scientific Assembly, the number of attendees dropped below that for the previous year, while costs exceeded the 1979 figure by over $2000.

This trend of rising costs and declining attendance has continued with each meeting since then:

MAG Scientific Assembly

	Cost	*Registration*	*No. of Specialty Programs*
1975	$11,061	403	12
1976	$14,398	528	13
1977	$22,261	891	16
1978	(Southern Medical Assn. in Atlanta)		
1979	$26,418	943	16
1980	$28,790	880	17
1981	$30,313	843	15
1982	(Southern Medical Assn. in Atlanta)		
1983	$35,004	732	15

The Scientific Assembly is concerned about the trend suggested by these statistics, and we wish to evaluate our annual meeting by means of an all-member survey in the MAG *Newsletter*. We ask for support from the House of Delegates in this endeavor.

As Chairman, I wish to thank the members of the

Scientific Assembly Committee for their support and involvement:

Edwin C. Evans, M.D. — Atlanta
Arthur J. Merrill, Jr., M.D. — Atlanta
Victor A. Moore, M.D. — Augusta
Carter Smith, Jr., M.D. — Atlanta
Roland S. Summers, M.D. — Savannah

Recommendation

The MAG, through its *Newsletter,* should conduct an all-member survey of members' attitudes toward the MAG Scientific Assembly. The Scientific Assembly Committee will evaluate the responses and make recommendations regarding possible revision of the Scientific Assembly to the 1985 House of Delegates.

House Action

Adopted.

Resolution 14

Human Life

W. Daniel Jordan, M.D., Delegate

RESOLVED, that the MAG House of Delegates in Annual Session in 1984 adopt the following statement as an ethical principle:

> "A physician should not condone the taking of human life in the practice of medicine but at all times respect the sanctity of human life, and seek to preserve or improve the quality of life."

House Action

Filed.

Resolution 15

Physician Manpower Oversupply

Medical Association of Atlanta

RESOLVED, that the Medical Association of Georgia through its officers and staff ADVISE all Georgia medical school faculty and deans of its concern regarding an impending physician oversupply not only in Georgia but in the entire United States, and be it further

RESOLVED, that the Medical Association of Georgia ask Georgia Medical School Deans to immediately consider plans for reduction in size of their freshman medical school classes, and, be it further

RESOLVED, that MAG ask Georgia medical school faculty and residency chiefs to immediately reconsider their current specialty residency allocations in view of GMENAC specialty projections, and be it

RESOLVED, that MAG advise the State Board of Medical Examiners of its concern regarding the impending physician oversupply and further ask the Board to consider the limitation of licensure of new medical school graduates from foreign senders with low standards, and be it further

RESOLVED, that the Medical Association of Georgia delegates recommend to the AMA House of Delegates that current AMA policy, (which holds that "the number of physicians, insofar as possible, be determined by the processes of the market"), be modified due to changing federal economic support and regulation of medical care which will adversely affect otherwise autonomous forces of the market place.

House Action

Adopted first, third, and fifth Resolves.

Adopted second Resolve amended as follows:

"RESOLVED, that the Medical Association of Georgia ask Georgia medical school deans to consider any and all available alternatives to rectify this problem."

Adopted fourth Resolve amended as follows:

"RESOLVED, that MAG advise the State Board of Medical Examiners of its concern regarding the impending physician oversupply and further ask the Board to *continue* the limitation of licensure of new medical school graduates from foreign and domestic centers with low standards."

Adopted a sixth Resolve:

"RESOLVED, that MAG advise the General Assembly of the impending physician oversupply."

Resolution 28

Opposition to NCI List of Physicians with "Expertise" in Cancer Care

Medical Association of Atlanta

RESOLVED, that the MAG express its opposition to the development of a list of physicians with "special expertise" in cancer care and to public access of such a list, and that the MAG Delegates to the AMA introduce the following Resolves to the AMA at its June, 1984 Annual Meeting:

Resolved, that the American Medical Association voice its opposition to the development by an agency of the federal government of a list of physicians with "special expertise" in cancer care and its opposition to *public* access to the list, and be it further

Resolved, that the American Medical Association request professional and legislative review of the appropriateness of these activities of the Cancer Information Service of the National Cancer Institute before the physician "referral" list is made public, and be it further

Resolved, that the American Medical Association insist that if such a list is to be made public by the National Cancer Institute through its National Cancer Information Service that such list be subject to outside professional review and approval prior to its availability to the public, and be it further

Resolved, that the American Medical Association insist on outside professional review and approval of the use of the PDQ Data Banks by the twenty-one regional centers of the National Cancer Information Service.

House Action

Adopted.

Report of Reference Committee on Constitution and Bylaws

Richard E. DuBois, M.D., Atlanta, Chairman
LaMar S. McGinnis, Jr., M.D., Decatur, Vice Chairman



Richard E. DuBois, M.D., Atlanta, Chairman of the Reference Committee on Constitution and Bylaws, gives the committee's report to the House.

In addition to the Chairman and Vice Chairman named above, the following persons served on the Reference Committee on Constitution & Bylaws: Alexander H. S. Weaver, M.D., Macon; Robert A. Lipson, MD, Marietta; John B. Rabun, MD, Savannah; H. Gordon Davis, Jr., MD, Sylvester; Neal F. Yeomans, MD, Waycross; and Chappell A. Collins, Jr., MD, Albany.

Interspecialty Council

Ellis B. Keener, M.D., Chairman

The MAG Interspecialty Council was established in 1975 by the Executive Committee with the following charge:

> The Interspecialty Council shall provide representation of all medical specialty societies in Georgia recognized by the MAG and shall maintain liaison with and serve in an advisory capacity to the specialty groups and the Council of the MAG. It shall consider all matters referred to it by the House of Delegates, Council, Executive Committee, or President of MAG, and shall work to integrate the various segments of the medical profession in Georgia. It shall report its activities regularly to the Council of the MAG.

On the average, we receive one assignment per year which calls upon us to act. In 1981, for instance, we drafted the MAG's position on "block grants"; in 1982 we helped research the issue of specialty society representation in the House. Recently, the Council as a whole has not been directed toward a specific project, though some of our members met at the request of MAG President Dr. William W. Moore to express opinions on the Medicaid department's plan for mandatory second surgical opinion.

We think this relative inactivity calls attention once again to the anomalous status of the Interspecialty Council. On the one hand, the Council is not a MAG committee, so we tend to be overlooked within the MAG organizational structure. On the other hand, the Council sometimes has difficulty representing the specialty societies in MAG matters — as when MAG officers or staff choose to deal with specialty society presidents, rather than the societies' representatives on the Interspecialty Council.

We therefore hope that our status will be clarified by the House of Delegates, and we have proposed a recommendation to that effect.

I wish to commend the members of the Interspecialty Council and to thank their respective specialty societies for their support over the years:

Thomas F. Smith, M.D.
Allergy and Immunology Society of Georgia
Thomas L. Tidmore, Jr., M.D.
Georgia Society of Anesthesiologists
Joseph I. Miller, M.D.
Georgia Thoracic Society
William L. Dobes, M.D.
Georgia Society of Dermatologists
Selwyn T. Hartley, M.D.
Georgia Chapter, American College of Emergency Physicians
Terrell B. Tanner, M.D.
Georgia Academy of Family Physicians
David E. Hein, M.D.
Georgia Gastroenterologic Society
William C. Waters, III, M.D.
Georgia Chapter, American College of Physicians
David E. Dalrymple, M.D.
Georgia Society of Internal Medicine
Richard D. Franco, M.D.
Georgia Neurological Society
Ellis B. Keener, M.D.
Georgia Neurosurgical Society
John T. Godwin, M.D.
Georgia Society of Nuclear Medicine
Samuel R. Poliakoff, M.D.
Georgia State OB/GYN Society
John H. Reed, M.D.
Georgia Society of Ophthalmology
Anthony Parke Avery, M.D.
Georgia Society of Otolaryngology — Head and Neck Surgery
Emmerich von Haam, Jr., M.D.
Georgia Orthopaedic Society
Robert E. DeLashmutt, M.D.
Georgia Association of Pathologists
David L. Morgan, M.D.
Georgia Chapter, American Academy of Pediatrics
E. A. Mussarra, II, M.D.
Georgia Society of Plastic Surgeons
Joseph B. Baird, Jr., M.D.
Georgia Psychiatric Association
William R. Elsea, M.D.
Georgia Chapter, American Association of Public Health Physicians

Richard S. Colvin, M.D.
Georgia Radiological Society
John I. Dickinson, M.D.
Georgia Chapter, American College of Surgeons
Thomas J. Florence, M.D.
Georgia Urological Society
Charles R. Underwood, M.D.
MAG Board of Directors

Recommendation

The MAG shall amend the status of the MAG Interspecialty Council to make it a Committee on Specialty Society Relations. Each state specialty society currently represented on the Interspecialty Council shall have a member on the Committee. Committee members will be nominated annually by the societies and approved by the MAG Executive Committee. Its charge will be: "The Committee shall maintain communications between MAG and the specialty societies and shall oversee the specialty society services performed by MAG."

House Action

Adopted the Recommendation with the following ~~deletion~~ in the last sentence: "Its charge will be: 'The Committee shall maintain communications between MAG and the specialty societies. ~~and shall oversee the specialty society services performed by MAG~~.'"

Report of the Committee on Committees

J. Rhodes Haverty, M.D., Chairman

Section I — General Recommendations

A. Establishment of Councils
The Committee recommends that:
1. All MAG committees be grouped into eight functional areas and that each group be overseen by a Council;
2. Each Council be composed of the chairmen of its several committees and be chaired by another Association member appointed by the Executive Committee (the Committee suggests that in most cases the Executive Committee should appoint members of the Board of Directors as Council Chairmen);
3. Each Council be charged with the responsibility of coordinating and supervising the activities of the several committees under its jurisdiction;
4. Recommendations of a committee requiring action by the House of Delegates be submitted to the appropriate Council prior to the Annual Session to assist in the coordination of all committee activities within that Council;
5. Reports of a committee without recommendations or with recommendations not requiring action by the House of Delegates be made directly to the appropriate body by the committee;
6. Each Council meet semi-annually, the first meeting being as soon as practical after the Annual Session for planning, and the second meeting prior to the following Annual Session for the purposes of receiving and acting upon committee recommendations.

It should be noted that three of the Councils — Legislation, Public Relations, and Judicial — have no separate committees under them. The Committee recommends that these continue to be structured and to function as committees, but have the status of Councils. That is, their activities would not be subject to coordination and supervision by another Council, and they would make recommendations directly to the House of Delegates.



(L to R) Drs. Stephen Boyle, Conyers; J. Rhodes Haverty, Atlanta; and Hugo S. Moreno, East Point.

B. Establishment of the President's Cabinet
The Committee recommends that the eight Council Chairmen be designated as the President's Cabinet to meet quarterly, with the MAG President presiding, for the purposes of considering the current and future activities of the Association and assigning tasks and projects to the several councils and committees.

C. Terms of Committee Members
The Committee recommends that the Executive Committee appoint committee members to serve two-year terms and that service on a committee be limited to three consecutive two-year terms.

D. Terms of Committee Chairmen
The Committee recommends that committee chairmen be appointed to one-year terms and be eligible for three consecutive terms and that Council chairmen be appointed for terms to be established by the Executive Committee;

E. Sunset
In order to ensure that committees continue to serve usefully, the Committee recommends that MAG adopt a procedure for the periodic review of all committees through a "sunset" process. The sunset process would follow these procedures:
1) Every committee would be established for a six-year period, following which it would be abolished automatically unless it is renewed.
2) Renewal of the committee would require positive action by the Executive Committee after its review of the effectiveness of the committee and the need for its existence;
3) Every year, approximately one-sixth of MAG committees would be scheduled for review;
4) To initiate this process, in the first fiscal year following the adoption of this report, one-sixth of the committees would be established for one-year terms and be subject to review after one year; if re-created, these would be established for full six-year periods; one-sixth of the committees would be established for two years; one-sixth for three years; one-sixth for four; one-sixth for five; one-sixth for full six-year terms.

Section II — Summary of Recommendations for Each Committee

Council	*Committees*	*Charge*	*# of Members*
Administration	Annual Session*	No Change	4†
	Building and Land	Amended Charge	3-5
	Constitution & Bylaws*	Amended Charge‡	5-7
	Finance*	No Change	4§
	Membership	No Change	3-5
	Trustee Advisory	Amended Charge	4
	Computer Advisory	Amended Charge†	3-5
Community Service	Public Health	No Change	7-9
	Prison Health Care	Amended Charge	12-15
	Nutrition	Amended Charge	5-7
	Medical Aspects of Sports	No Change	5-7
	Maternal & Infant Health	Amended Charge	12-15
	Emergency Medical Services	No Change	3-5
	Cancer	Amended Charge‡	12-15
	Access to Health Care	No Change	5-7
Legislation	No separate committee	No Change	12-15
Education	Continuing Medical Education‖	New Charge	7-9
	Scientific Assembly*	Amended Charge‡	8
	Medical Schools‖	New Charge	7-9
	Health Education‖	New Charge	12-15
Judicial*	No separate committee	No Change	5
Membership Services	Medical Practice	Amended Charge	7-9
	Medicine & Human Values	No Change	5-7
	Membership Insurance	Amended Charge#	12-15
	Impaired Physicians	Amended Charge‡	12-15
	Consultant Committee to Impaired Physicians Committee	Amended Charge ‡	12-15
	Computer Education	No Change	5-7
Liaison	Auxiliary*	No Change	7-9
	Composite State Board of Medical Examiners	Amended Charge	3-5
	Cost Awareness	Amended Charge‡	5-7
	Occupational Health	No Change	12-15
	Physician/Lawyer Liaison	No Change	3-5
	Third Party Payors	Amended Charge	7-9
	Specialty Society Relations**	New Charge	20-25
	Non-Physician Health Care Providers**	New Charge	12-15
Public Relations	No separate committee	Amended Charge	12-15

Notes:

*Standing Committee — Established in Bylaws
†Ex-officio Membership — Established by Executive Committee Action
‡Charge amended only to require that reports be made to the appropriate Council
§Membership provided in Bylaws
‖Formed by splitting responsibilities of the present Education Committee
#Charge expanded to encompass professional liability and risk management
**New committee proposed

Committees to be abolished:

Education
Peer Review
Professional Liability Insurance
Crawford W. Long
Chiropractic
Physicians Assistants
Medical Assistants
Clinical Labs
Risk Management
Nursing
Drugs
Talmadge Hospital
Health Planning
Freestanding Emergency Centers

Section III — Proposals for Each Council and Committee

COUNCIL ON ADMINISTRATION

Proposed Charge:

The primary function of this Council is to oversee, advise, and coordinate the management of the business affairs of the Association. A plan of action should include immediate, intermediate, and long-range planning.

The Council on Administration shall advise, direct, and manage the administrative affairs of the MAG subject to approval by the Board of Directors and shall coordinate these functions with the administrative staff of the Association.

Committees:

- Annual Session
- Building and Land
- Constitution and Bylaws
- Finance
- Membership
- Trustee Advisory
- Computer Advisory

Annual Session Committee

Present Charge:

The Committee on Annual Session shall carry out the approved policies of the Association as directed by the Board of Directors. It shall study and make recommendations concerning the Annual Session of the Association. The Committee shall submit a budget for the Annual Session to the Finance Committee.

Proposed New Charge:

No change.

4 members

Building and Land Committee

Present Charge:

The Committee on Building and Land shall be advisory to the Executive Committee and the Board of Directors with respect to the MAG Headquarters building. The Committee shall keep itself apprised of the condition, appearances, value, and current and planned utilization of the property. The Committee shall consider any and all proposed structural changes or utilization of the building as are referred to it by the Executive Committee or the Board of Directors, on an ad hoc basis.

Proposed New Charge:

The Building and Land Committee shall be responsible in an advisory capacity for evaluating all significant additions and/or alterations of a structural nature to the MAG Headquarters building and land; shall evaluate any offers to purchase, sell or lease said building and land or other real estate, in part or in toto, and shall submit to the Council on Administration a report on all activities with accompanying fiscal data along with the Committee's recommendation for a plan of action.

3-5 members.

Constitution and Bylaws Committee

Present Charge:

The Committee shall be responsible for the continuing study of the organization of the MAG. It shall recommend to the House of Delegates through the Board of Directors any amendments or revisions which seem necessary or advisable. At least every five years, the committee shall recommend revisions after a complete study of the organization of the Association and its Constitution and Bylaws. Proposed amendments shall be referred to the Committee on Constitution and Bylaws for recommendation before action thereon is taken by the House of Delegates.

Proposed New Charge:

The Committee shall be responsible for the continuing study of the organization of the MAG. It shall recommend to the House of Delegates through the Council on Administration and the Board of Directors any amendments or revisions which seem necessary or advisable. At least every five years, the Committee shall recommend revisions after a complete study of the organization of the Association and its Constitution and Bylaws. Proposed amendments shall be referred to the Committee on Constitution and Bylaws for recommendation before action thereon is taken by the House of Delegates.

5-7 members.

Finance Committee

Present Charge:

The Committee shall propose an annual budget for the fiscal year beginning June 1st and running through May 31st. This proposed budget shall be prepared by the Committee on Finance for the consideration of the Board of Directors at the last meeting in the last quarter of each fiscal year. This budget shall be presented to the House of Delegates for its approval. It shall also submit an annual report to the House of Delegates which shall specify the character of all of its property and shall provide full information concerning the management of all affairs of the Association which the Board of Directors is charged to administer.

All expenditures made by the Local Arrangements Committee in connection with the Annual Session must be authorized in advance by the Committee on Finance. The Board of Directors shall have control of all commercial exhibits of the Annual Session and any deficit created on account of the Annual Session shall be met by the Board of Directors on recommendation of the Committee on Finance.

Proposed New Charge:

No change.

Membership:

Three members of the Board of Directors appointed by the Chairman of the Board. The MAG Treasurer is ex-officio Chairman (Bylaws, Chapter 10, Section 3). No change proposed.

Membership Committee

Present Charge:

Established to develop recruitment programs to attract new members and to retain present members.

Proposed New Charge:

No change.

3-5 members.

Trustee Advisory Committee

Present Charge:

That the Treasurer of the Association assume the duty of Trustee of the Retirement Fund; appoint a Trustee Advisory Committee to be composed of the Association Secretary, and an Association Past President or other Association member who is knowledgeable in financial investing, and the Executive Director, recommending that the physician members serve three to five year terms to provide continuity; that quarterly reports be given to the Executive Committee by Trustee, first quarter beginning October 15th; that the Executive Committee review the actions of the Trustee and the Advisory Committee at the time of other committee appointments and make any necessary changes at that time.

Proposed New Charge:

The Trustee Advisory Committee shall be composed of the Association's Treasurer, Secretary, and Executive Director, and a Past President of the Association, the Treasurer shall be chairman. The charge of the Trustee Advisory Committee shall be to oversee the Retirement Fund of the Association.

4 members.

Computer Advisory Committee

Present Charge:

Have general oversight responsibility for the computer activities of the Information Systems Department. It will review with Information Systems staff all budget requests, as well as all new projects of significant size and impact, and will make periodic reports to the Executive Committee.

Proposed New Charge:

The Committee shall have general oversight responsibility for the computer activities of the Information Systems Department. It will review with Information Systems staff all budget requests, as well as all new projects of significant size and impact, and will make reports to the Council on Administration.

3-5 members.

COUNCIL ON COMMUNITY SERVICE

Proposed Charge:

This Council shall be responsible for those activities of the Association which serve to benefit the community as a whole. Such activities shall encompass public education in the area of health care and other programs which promote the betterment of public health through communication with and service to the lay public.

Committees:

Public Health
Prison Health Care
Nutrition
Medical Aspects of Sports
Maternal and Infant Health
Emergency Medical Services
Cancer
Access to Health Care

Public Health Committee

Present Charge:

Established to promote the betterment of the public health in Georgia by developing and distributing educational materials on specific subjects and problems to the public and to the practicing physicians.

Proposed New Charge:

No change.

7-9 members.

Prison Health Care Committee

Present Charge:

Established to study and recommend ways to improve the delivery and promote the availability of health care in non-federal prisons in Georgia. This Committee will have responsibility for liaison with appropriate state agencies and with other committees interested in health care in the prison system.

Proposed New Charge:

Established to study and recommend ways to improve the delivery and promote the availability of adequate professional health care in Georgia's prisons and jails. This Committee shall provide resources to assist physicians and other health care providers within correctional facilities to meet standards of professional health care as determined by the American Medical Association and this Committee, and to provide those who meet such standards with recognition in the form of accreditation. This Committee shall have responsibilities for liaison with appropriate state agencies and organizations and with other MAG committees in achieving these objectives and shall serve as a resource for physicians who provide care to inmates.

12-15 members.

Nutrition Committee

Present Charge:

Charged with the responsibility of investigating and disseminating up-to-date nutritional information which will be provided to MAG members and to the public. When such findings affect legislation, clearance must be obtained from the Executive Committee or the Board of Directors before such findings are publicly disseminated.

Proposed New Charge:

Charged with the responsibility of investigating and disseminating up-to-date nutritional information which will be provided to MAG members and to the public.

5-7 members.

Medical Aspects of Sports Committee

Present Charge:

Established to study the medical problems of the athlete and to provide medical information and advice to coaches and other lay groups who are concerned with athletics.

Proposed New Charge:

No change.

5-7 members.

Maternal and Infant Health Committee

Present Charge:

Established and charged with the responsibility of seeking out information on all aspects of maternal and infant health in Georgia; to cooperate whenever possible (consistent wtih MAG policy) with appropriate state and local agencies also interested in improving maternal and infant health in Georgia; to serve as liaison among pediatricians, obstetricians, and family physicians; and to make recommendations to the Executive Committee of the Board of Directors of the MAG designed to improve maternal and infant health of Georgia citizens and doing whatever may seem appropriate to accomplish these objectives.

Proposed New Charge:

Established and charged with the responsibility of seeking out information on all aspects of maternal and infant health in Georgia; to cooperate whenever possible (consistent with MAG policy) with appropriate state and local agencies also interested in improving maternal and infant health in Georgia; to serve as liaison among pediatricians, obstetricians, and family physicians; and to make recommendations to the Council on Community Service.

12-15 members.

Emergency Medical Services Committee

Present Charge:

Established to encourage and coordinate Georgia physicians and state and federal agencies to work together in the development of a logical, systematized, and medically sound emergency health services delivery system in Georgia.

Proposed New Charge:

No change.

3-5 members.

Committee on Cancer

Present Charge:

The Committee is established to provide a coordinating relationship between the MAG, the Georgia Department of Human Resources, the Division of Cancer Control and the Georgia Division of the American Cancer Society by making policy recommendations to MAG on matters relating to cancer and cancer control and overseeing any MAG activity on programs relating to cancer.

Proposed New Charge:

The Committee is established to provide a coordinating relationship between the MAG, the Georgia Department of Human Resources, the Division of Cancer Control, and the Georgia Division of the American Cancer Society by making policy recommendations to the Council on Community Service on matters relating to cancer and cancer control and overseeing any MAG activity on programs relating to cancer.

12-15 members.

Access to Health Care Committee

Present Charge:

The Committee is established to plan and conduct programs to improve access to health care in Georgia. A principal method of providing this service is assisting in the recruitment and retention of physicians in localities where there is a need for additional physicians.

Proposed New Charge:

No change.

5-7 members.

COUNCIL ON LEGISLATION

Present Charge of the Committee on Legislation:

Established to continually review pending legislation, active bills, and the need for particular legislation, recommend positions of policy to policymaking bodies of MAG, and communicate the MAG position to congressmen and state legislators.

Proposed New Charge:

No change.

12-15 members.

COUNCIL ON EDUCATION

Proposed Charge:

The Council shall be responsible for the development of high quality continuing education programs for physicians throughout the state. It shall also be responsible for promoting health education in schools, public and private, and for promoting health education for the general public.

The Council shall maintain liaison with the medical schools and other institutions and agencies which also provide health and medical education.

The Scientific Assembly Committee, under the direction of the Council on Education, shall plan and conduct such scientific meetings as it considers necessary and beneficial to the membership of the MAG and the medical profession as a whole of the State of Georgia. It shall also plan and conduct meetings relating to the business aspects of the practice of medicine. It shall offer its help and expertise to allied health organizations who may need or ask for this help.

Committees:

Scientific Assembly
Medical Schools
Continuing Medical Education
Health Education

Scientific Assembly Committee

Present Charge:

The Committee shall conduct such general scientific meetings as it considers beneficial to the membership of the MAG and the medical profession as a whole in the State of Georgia, consistent with the affirmed policies of the Association as directed by the Board of Directors and the House of Delegates. The Committee shall submit a budget for these general scientific meetings to the Finance Committee. The Committee shall consist of a Chairman, appointed annually by the Executive Committee, and by reason of their offices, the current Chairmen of the Committee on Specialty Society Relations and the Committee on Education.

Proposed New Charge:

The Committee shall conduct such general scientific meetings as it considers beneficial to the membership of

the MAG and the medical profession as a whole in the State of Georgia, consistent with the affirmed policies of the Association as directed by the Board of Directors and the House of Delegates. The Committee shall submit a budget for these general scientific meetings. The Committee shall consist of a Chairman, appointed by the Executive Committee, and by reason of their offices, the current Chairman of the Committee on Specialty Society Relations and the Chairmen of the other committees in the Council of Education.

8 members.

Continuing Medical Education Committee

Proposed Charge:

The Committee will foster the development of high-quality continuing medical education (CME) programs for physicians throughout the state, as offered by hospitals, specialty societies, and other agencies which provide medical and health education. As directed by the Accreditation Council for Continuing Medical Education, it will supervise the accreditation of intrastate CME providers. The Committee will also review educational programs sponsored by nonaccredited CME providers and authorize when appropriate, the awarding of CME credit.

7-9 members.

Medical Schools Committee

Proposed Charge:

The Committee will maintain liaison with the state's medical schools, and will be responsible for planning periodic conferences on medical education on topics pertinent to both practitioners and the medical academic community.

7-9 members.

Health Education Committee

Proposed Charge:

The Committee will promote health education in cooperation with hospitals, voluntary health agencies, and other groups, especially those involved in patient education and health education in the schools. The Committee will also assist the MAG Committee on Occupational Health in promoting health education at the work place.

12-15 members.

JUDICIAL COUNCIL

Present Charge:

a) To serve as the judicial authority of the Association. The decisions of the Judicial Council shall be final.

b) To have original jurisdiction with respect to: (1) all questions involving membership as provided in Chapter II of the Bylaws; (2) all controversies arising under the Association's Constitution and Bylaws and under the Principles of Medical Ethics to which the Medical Association of Georgia is a party; (3) all controversies between two or more component societies or their members; (4) the establishment of principles and interpretation of medical ethics; (5) the interpretation of the Constitution and Bylaws and policies of the Association; (6) referrals from component county medical societies when such societies request that the Association assume original jurisdiction of the matter in behalf of such county societies, provided that the Judicial Council approves acceptance of original jurisdiction of such matters; and (7) direct appeals by complainants when the component county medical societies having original jurisdiction have not commenced investigation within 30 days after receipt of the complaint.



Delegates from Richmond County Medical Society in Augusta include Drs. James O'Quinn, Luther Thomas, Leon Bush, Theodora Vanderzalm, and Joe Bailey.

c) To have appellate jurisdiction in questions of law and procedure but not of fact in all cases which arise within the Medical Association of Georgia and two or more of its component societies, between a member or members and the component society to which said member or members belong or between members of different component societies of the Association. Notice of appeal shall be filed with the Judicial Council within thirty days of the date of the disputed decision and the appeal shall be perfected within sixty days thereof; provided, however, that the Judicial Council, for what it considers good and sufficient cause may grant an additional thirty days for perfecting the appeal.

d) To receive appeals filed by applicants who allege that they, because of color, creed, race, religion, ethnic origin, national origin, or sex, have been unfairly denied membership in a component and/or constituent association, to determine the facts in the case, and to report the findings to the House of Delegates. If the Council determines that the allegations are indeed true, it shall admonish, censure, or, in the event of repeated violations, recommend to the House of Delegates that the component society involved be declared to be no longer a constituent member of the Medical Association of Georgia.

e) To investigate general ethical conditions and all matters pertaining to the relations of physicians to one another or to the public, and make recommendations to the House of Delegates.

f) To request the President to appoint investigating juries to which it may refer complaints or evidences of unethical conduct which in its judgment are of greater than local concern. Such investigating juries, if probable cause for action be shown, shall submit formal charges to the President, who shall appoint a prosecutor to prosecute such charges against the accused before the Judicial Council in the name and on behalf of the Medical Association of Georgia. The Council may acquit, admonish, suspend, or expel the accused.

g) To approve applications and nominate candidates for affiliate membership as otherwise provided for in these Bylaws.

Proposed New Charge:

No change.

4-5 members.

COUNCIL ON MEMBERSHIP SERVICES

Proposed Charge:

The benefits of MAG membership, which are the services it provides, shall be made available to prospective and present members. These benefits include professional liability insurance, ongoing assessment of the practice climate, ethical and legal constraints, MAG policies related to membership (hospital relations, paramedical relations, etc.), location assistance, and other services as they become available.

Committees:
- Computer Education
- Medical Practice
- Medicine and Human Values
- Membership Insurance
- Impaired Physicians
- Consultant Committee to Impaired Physicians Committee

Committee on Computer Education

Present Charge:

The Committee will oversee the Association's marketing activities for the AMA/GTE Medical Information Network; and as part of those activities will conduct programs to educate physicians on the applications of computers in the medical office.

Proposed New Charge:

No change.

5-7 members.

Medical Practice Committee

Present Charge:

Established to study health care financing and national health insurance; to promote liaison between physicians and hospitals and their organizations; and to encourage the private practice of medicine.

Proposed New Charge:

To promote the private practice of medicine by evaluating changing health care patterns, including quality of care, access, and finance. The strengths and weaknesses of possible changes shall be evaluated and the possible impact of these changes on private health care explained to the membership. This committee shall also have responsibility for promoting liaison between physicians and hospitals.

7-9 members.

Medicine and Human Values Committee

Present Charge:

To provide information to the MAG membership about issues related to human values which affect medical practice; it will also suggest programs, activities, legislation, etc., which support the preservation of such values both in the medical profession and in the community as a whole.

Proposed New Charge:

No change. 5-7 members.

Membership Insurance Committee

Present Charge:

Established to study the various insurance programs that could be provided to the membership on a group rate basis or as sponsored programs.

Proposed New Charge:

The charge of this Committee shall be three-fold. The Committee shall (1) objectively assess professional liability insurance carriers as to quality, availability, and cost of coverage; (2) provide courses on risk management for Georgia physicians; and (3) evaluate other general insurance coverage.

12-15 members.

Impaired Physicians Committee

Present Charge:

The Committee shall be responsible for overseeing the activities of the program in Georgia, and the activities of the Physician's Consultant Committee, in an effort to reach every physician in Georgia who is chemically dependent on drugs/alcohol, seeking their treatment and recovery. The Committee shall make timely reports on its activities and the direction in which the program is moving to either the MAG Executive Committee or Board of Directors.

Proposed New Charge:

The Committee shall be responsible for overseeing the activities of the program in Georgia, and the activities of the Physician's Consultant Committee, in an effort to reach every physician in Georgia who is chemically dependent on drugs/alcohol, seeking their treatment and recovery. The Committee shall make timely reports on its activities and the direction in which the program is moving to the Council on Membership Services.

12-15 members.

Consultant Committee to the Impaired Physicians Committee

Present Charge:

Shall administratively and operationally report to the Impaired Physicians Committee. Shall receive permission from the Impaired Physicians Committee to contact and involve all physicians in the Impaired Physicians Program; all correspondence to the Executive Committee of the Medical Association of Georgia, Georgia Hospital Administrators, Nursing Association of Georgia, Pharmacy Association of Georgia, etc., shall be sent initially to the Impaired Physicians Committee for transmittal; shall initiate contact with physicians reported to have alcohol, drug, or psychiatric problems for involvement in the Impaired Physicians Program; shall make repeated efforts to involve an impaired physician in the program — only after it fails, shall the Impaired Physicians Committee be notified and become involved; shall send two members from another geographic part of the State of Georgia to see an impaired physician initially and attempt to enlist him in the program; shall visit the doctor's home community, hospital, and hospital board or authority following completion of the program and periodically thereafter to help the impaired physician in his re-entry phase back into medical practice; membership

of the committee shall be periodically expanded by addition of graduates of the Impaired Physicians Program; shall meet on a scheduled basis with the Impaired Physicians Committee to discuss the policy, problem, and individual cases of the Impaired Physicians Program.

Proposed New Charge:

No change.

12-15 members.

COUNCIL ON LIAISON

Proposed Charge:

The Council is charged with coordinating the Association's communication with other organizations in the health care field.

Committees:

Auxiliary
Composite State Board of Medical Examiners
Cost Awareness
Occupational Health
Non-Physician Health Care Providers
Physician/Lawyer Liaison
Third Party Payors
Specialty Society Relations

Auxiliary

Present Charge:

The Committee on Auxiliary shall cooperate with, advise, and direct the Auxiliary in all matters concerning the Association.

Proposed New Charge:

No change.

7-9 members.

Composite State Board of Medical Examiners Committee

Present Charge:

The Committee is established to conduct an in-depth study of all relevant aspects of the Composite State Board of Medical Examiners and the Medical Practice Act as the same may impact on the practice of medicine with a view toward evaluating the Board and the law in a sincere effort to help the Board improve its performance and maintain favorable credibility with public, government, and the profession.

Proposed New Charge:

Established to provide exchange of information between the Composite State Board of Medical Examiners and MAG.

3-5 members.

Cost Awareness Committee

Present Charge:

The Committee is charged to study health care costs in an effort to control their rise without reducing the quality of care available to patients; to interact with similar committees at the hospital and county medical society levels in order to share information on controlling rising costs; monitor, interface with, and coordinate the activities of state, regional, and local coalitions with the business community and others; and to make recommendations to the MAG Board of Directors or the House of Delegates to establish MAG policy positions on controlling rising costs of health care.

Proposed New Charge:

The Committee is charged to study health care costs in an effort to control their rise withut reducing the quality of care available to patients; to interact with similar committees at the hospital and county medical society levels in order to share information on controlling rising costs; monitor, interface with, and coordinate the activities of state, regional, and local coalitions with the business community an others; and to make recommendations to the Council on Liaison to establish MAG policy positions on controlling rising costs of health care.

5-7 members.

Occupational Health Committee

Present Charge:

Established to inform the physicians in Georgia of the significant changes in the field, particularly in the areas of Worker's Compensation, rehabilitation, and occupational safety.

Proposed New Charge:

No change.

12-15 members.

Committee on Non-Physician Health Care Providers

Present Charge:

This committee is established to maintain liaison with non-physician health care providers and their associations. The Committee will study and make recommendations on actions taken by or relating to non-physician health care professions which have an actual or potential impact on the practice of medicine. The Committee will propose ways in which MAG can cooperate in programs with other health care professions to promote the goals of MAG.

12-15 members.

Physician/Lawyer Liaison Committee

Present Charge:

Established to promote better understanding, professional cooperation, and harmonious approaches to matters of interest by both the physician and the attorney.

Proposed New Charge:

The Liaison Committee for Physicians and Lawyers will be responsible for overseeing the interrelationships between physicians and lawyers and their respective state professional associations in Georgia. The Committee will attempt to promote better understanding and harmony between the two professions.

3-5 members.

Third Party Payors Committee

Present Charge:

Established to promote liaison with health insurors — private and public — in order to provide a forum for discussion of physician insurors problems; to investigate the insurors' basis for reimbursement, methods of claim processing and benefit packages available; and to review

federal and state health programs and make their findings on the programs available to the MAG membership.

Proposed New Charge:

The Liaison Committee with Third Party Payors will oversee the relationships between the Association and health insurors — both private and public. The Committee will help to provide a forum for discussion of issues between and among the Association and the insurors. The committee will be responsible for investigating the insurors' basis of reimbursement, for methods of claims processing, and for the benefits packages available. The Committee will review federal and state health programs, and make its findings available to the Association membership.

7-9 members.

Committee on Specialty Society Relations

Proposed Charge:

The Committee shall maintain communication between MAG and the specialty societies and shall oversee the specialty society services performed by MAG.

20-25 members.

COUNCIL ON PUBLIC RELATIONS

Present Charge of Committee on Public Relations:

Established to provide advice, assistance, and coordination for all other committees on communications with the membership and the public.

Proposed Charge for the Council on Public Relations:

The Public Relations Council is to provide advice and assistance, upon request, to MAG committees, the Board of Directors, and the House of Delegates in communicating the Association's positions and policies to the public.

The Council is also charged with making recommendations as to an annual budget that will serve the best interests of the Association in relating to the public and is further charged as being the oversight committee for MAG's Public Relations Department.

11-13 members.

House Action

Adopted Recommendations A1, A2, and A3 (see page 418).

Adopted Recommendation A4 with the following amendment by addition: "Recommendations of a committee requiring action prior to the House of Delegates or appropriate Council meeting be submitted to the Board of Directors or Executive Committee for approval."

Adopted Recommendation A5 with the following amendment by substitution "Reports of a committee without recommendations or with recommendations not requiring action by the House of Delegates be made directly to the Executive Committee or Board of Directors." However, all annual reports submitted shall be included in the Delegates' Handbook.

Adopted Recommendation A6 as amended by addition to read: "Each Council meet at least semiannually. . . . "

Adopted Recommendations B, C, D, and E as presented.

Adopted an additional Recommendation F to read as follows: "F, Disclaimer. Any public statement or position made by a committee or Council which could be interpreted as new MAG policy must have prior approval of the Executive Committee, Board of Directors, or House of Delegates."

"Section III — Proposals for Each Council and Committee" — Adopted the proposed Councils and Committees with the following amendments:

Prison Health Care Committee — Under the Proposed New Charge, the words "as available" were added in the second sentence so as to read, "This Committee shall provide resources as available to assist physicians. . . ."

Access to Health Care Committee — Amended the title of the committee by substitution as follows: Access to Medical Care Committee. Also, in the first sentence of the Present Charge, deleted health and added medical so as to read: " . . . to improve access to medical care. . . . "

Council on Education — Added the following sentence to the last of the third paragraph under Proposed Charge: It is expected that joint meetings of this Council's committees will frequently be necessary."

Medical Schools Committee — Amended by addition in the first sentence of the Proposed Charge the words and Talmadge Hospital, so the sentence would read: "The Committee will maintain liaison with the state's medical schools and Talmadge Hospital and will be responsible for planning periodic conferences. . . ."

Committee on Specialty Relations — Adopted as amended by deletion as follows: "The Committee shall maintain communication between MAG and the specialty societies ~~and shall oversee the specialty society service performed by MAG~~." Adopted a further amendment on the last line by substitution of "20-25 members" by "equal to the number of approved specialty societies."

Report A

Constitution and Bylaws Committee

J. Rhodes Haverty, M.D., Chairman

Your Committee on Constitution and Bylaws now presents an amendment to the Constitution and Bylaws which has lain on the table for one year.

This amendment is to Article V, House of Delegates, Section 1, Composition. This article, if amended, would then read, (new language underlined),

"The House of Delegates is composed of delegates elected by the component county medical societies, the House Officers Section, Georgia Medical Schools, Medical Staff Section, and delegates elected by specialty societies which are represented on MAG's Interspecialty Council ~~as provided for in the Bylaws~~. All delegates' qualifications and terms of office shall be provided for in the Bylaws."

House Action

Adopted the Recommendation as amended by deletion: The House of Delegates is composed of delegates elected by the component county medical societies, the House Officers Section, Georgia Medical Schools, Medical Staff Section. All delegates' qualifications and terms of office shall be provided for in the Bylaws.

Report B
Constitution and Bylaws Committee
J. Rhodes Haverty, M.D., Chairman

Your Constitution and Bylaws Committee was asked to draft proposed language which would amend Chapter II, Section 1 of the Bylaws-ACTING MEMBERS, which would allow for Osteopathic membership in the Medical Association of Georgia.

After careful consideration, your Bylaws Committee presents the following amendment for your consideration. If approved, the amendment would amend by deletion and substitution Subsection A (i) (ii):

Active Members. Active members are members of the Medical Association of Georgia who are entitled to exercise the rights of membership in their county medical societies, including the right to vote and hold office, as determined by their respective county medical societies and who fulfill at least one of the following requirements:

A. Possess the degree of Doctor of Medicine (or its equivalent).
B. Possess an unrestricted license to practice medicine and surgery in the State of Georgia. (Editors Note. The Composite State Board of Medical Examiners does not differentiate on their examinations or licenses between Doctors of Medicine and Osteopathy, both are given an unrestricted license to practice medicine and surgery in the state.)
C. Are residents serving in training programs approved by the Composite State Board of Medical Examiners of Georgia or any predecessor or successor body authorized to license Doctors of Medicine and be certified by the secretary of a component society as being a member in good standing of such component society.

House Action

Adopted the following substitute amendment: That this proposed amendment be forwarded to a special committee of the House for further study and report back its findings to the 1985 House of Delegates.

Report C
Constitution and Bylaws Committee
J. Rhodes Haverty, M.D., Chairman

Your Constitution and Bylaws Committee wishes to offer the following amendments to the Bylaws of the MAG.

Our first proposal deals with clarification of who shall pay half year dues. Our membership department states that several members pay a year's dues, drop out, then reapply the next year in July and want to pay only half year dues. Your Constitution and Bylaws Committee and your Membership Committee feel this should conform with the AMA's Constitution and Bylaws and only first time members should be entitled to half year dues when applying in or after July.

Therefore, we would amend by addition, Chapter II, Active Members, Section 1, subsection b, third sentence, as follows (note new language is underlined):

"A physician applying for active membership after July 1 of any year, <u>who is applying for membership in the Medical Association of Georgia for the first time,</u> shall pay one half the annual dues. . . ."

The next proposed amendment is to Chapter II, Section 11, Tenure. While the Medical Association of Georgia does have a policy concerning the removal of a member when they no longer have a license to practice, we feel very strongly this should be contained in the Bylaws. MAG attorneys informed the MAG staff the easiest way to provide for this was in this particular section, which reads, "when the secretary is officially informed that a member is not in good standing in the respective county society, the secretary shall remove the name of that member from the membership rolls."

This would be amended by addition, to read, "when the secretary is officially informed that a member is not in good standing in the respective component society or <u>no longer holds a valid license to practice medicine in the State of Georgia,</u> the secretary shall remove the name of that member from the membership rolls."

This next amendment would amend by addition, Chapter IV — House of Delegates, Section 2, Composition, by adding two new paragraphs. (Note the addition of this amendment requires passage of the Constitutional amendment calling for the addition of a medical staff section delegate and specialty society delegates in the House; failure of that constitutional amendment would automatically withdraw this amendment.)

"<u>The Medical Staff Section shall be entitled to one voting delegate and alternate delegate. These delegates shall be elected each year by the Section and shall be members in good standing with the Medical Association of Georgia.</u>"

"<u>Each medical specialty society, which is represented on MAG's Interspecialty Council shall be entitled to one voting delegate and one alternate delegate. These delegates shall be elected by the specialty society each year and shall be members in good standing with the specialty society and the Medical Association of Georgia</u>."

The final proposal would amend Chapter IX, Section 2, Subsection C, Dues & Assessments: The current Bylaws read "that an active member who fails to pay dues for one year, may be reinstated without reapplication upon payment of the current and past year's dues." There is no dues penalty for those being out for more than one year. The Constitution and Bylaws Committee members felt that this was a detriment to membership as it has caused many complaints by former members and financially distressed members who wish to be members but cannot afford the "two years" dues at one time. The Committee felt that this was an error in placing the one year in arrears dues back in the Bylaws and wish to amend by deletion, so this amended section, if approved, would read as follows:

"An active member who fails to pay dues for one year, may be reinstated without reapplication upon payment of the current year's dues ~~and past year's dues~~, provided there is no objection by the respective county medical society."

House Action

Adopted amendment to Chapter II, Section 1, subsection b, third sentence.

Adopted amendment to Chapter II, Section 11, Tenure.

Adopted amendment to Chapter IV, Section 2, first paragraph.

Did not adopt amendment to Chapter IV, Section 2, second paragraph.

No action was taken on Chapter IX, Section 2, Subsection C, Dues & Assessments.

Resolution 3

Medical Student Section of MAG

Richmond County Medical Society

RESOLVED, that a Medical Student Section of the Medical Association of Georgia be officially recognized, and be it further

RESOLVED, that each medical school having a non-voting delegate to the MAG House of Delegates have that delegate represent the concerns of each student chapter.

House Action

Adopted.

Resolution 6

Amendment to the MAG Constitution and Bylaws

Peachbelt Medical Society

RESOLVED, that the Medical Association of Georgia House of Delegates instruct the MAG Constitution and Bylaws Committee to draft the proper language and introduce to the 1985 House of Delegates the following amendments to the MAG Constitution and Bylaws:

Amendment by addition to the Constitution of the Medical Association of Georgia (proposed addition is underlined):

ARTICLE V — HOUSE OF DELEGATES

SECTION 1. COMPOSITION. The House of Delegates is composed of delegates elected by the component county medical societies as provided for in the Bylaws, and the President of each component county society.

Amendment by addition to the Medical Association of Georgia Bylaws (proposed additional statement is underlined):

CHAPTER IV — HOUSE OF DELEGATES

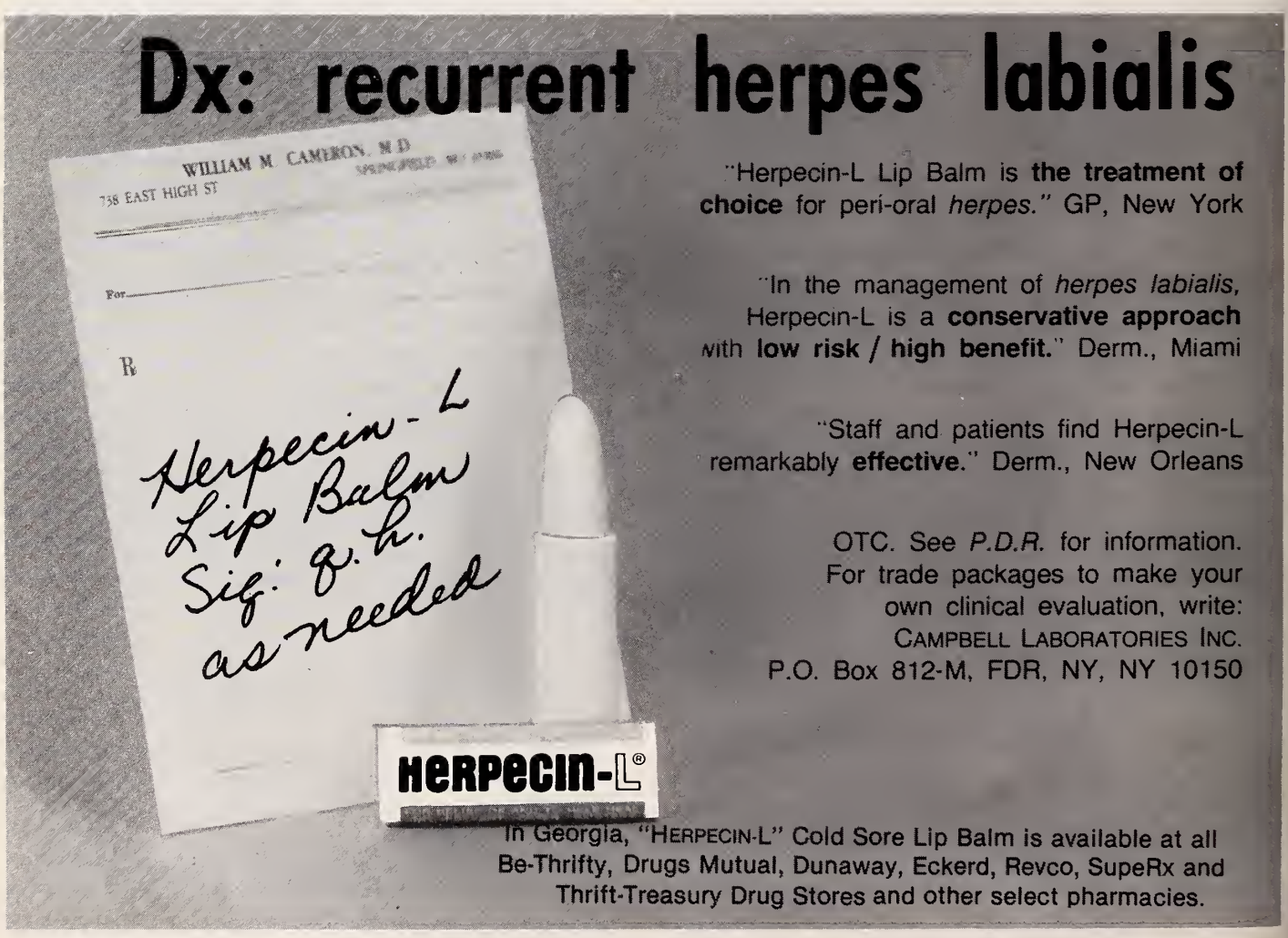
Section 2. COMPOSITION.

We propose that the following paragraph be added at the end of this section:

In addition to the elected delegate and corresponding alternate delegate from each component county society, the President and President-Elect of each component county society shall also be a voting delegate and corresponding alternate delegate to the House of Delegates.

House Action

Did not adopt.




When
monotherapy fails
in hypertension...


SQUIBB

The power to control hypertension... with greater convenience

A COMBINATION OF TIME-PROVEN AGENTS

for an additive effect in reducing hypertension*

- ☐ CORZIDE combines the advantages of CORGARD® (nadolol) — the highly effective once-a-day beta-blocker — and a classic once-a-day thiazide
- ☐ CORZIDE reduces blood pressure, as demonstrated in clinical trials

for a low incidence of side effects†

- ☐ CORZIDE was well tolerated in 102 patients evaluated for adverse reactions
- ☐ Hydrophilic (water-soluble) CORGARD does not readily cross the blood-brain barrier and is likely to cause fewer CNS side effects than lipophilic agents

for superior convenience

- ☐ Simple once-a-day dosage enhances patient compliance
- ☐ May be administered without regard to meals
- ☐ Available in two tablet strengths:
  CORZIDE® 40/5 (Nadolol 40 mg and Bendroflumethiazide 5 mg per tablet)
  CORZIDE® 80/5 (Nadolol 80 mg and Bendroflumethiazide 5 mg per tablet)

*This fixed combination drug is not indicated for initial therapy of hypertension. It may be appropriate if the fixed combination represents the dosage as titrated to the individual patient's needs.

†Please see brief summary of prescribing information on the last page of this advertisement for a discussion of CONTRAINDICATIONS, PRECAUTIONS, ADVERSE REACTIONS and WARNINGS, including avoidance of abrupt withdrawal.

ONCE-A-DAY

CORZIDE®

Nadolol-Bendroflumethiazide Tablets

An important advance in Step-2 antihypertensive therapy

For brief summary please see next page.

ONCE-A-DAY CORZIDE®

Nadolol-Bendroflumethiazide Tablets

SQUIBB

An important advance in Step-2 antihypertensive therapy

CORZIDE® 40/5
CORZIDE® 80/5
Nadolol-Bendroflumethiazide Tablets

DESCRIPTION: CORZIDE (Nadolol-Bendroflumethiazide Tablets) for oral administration combines two antihypertensive agents: CORGARD® (nadolol), a nonselective beta-adrenergic blocking agent, and NATURETIN® (bendroflumethiazide), a thiazide diuretic-antihypertensive. Formulations: 40 mg and 80 mg nadolol per tablet combined with 5 mg bendroflumethiazide.

CONTRAINDICATIONS: Nadolol — Bronchial asthma, sinus bradycardia and greater than first degree conduction block, cardiogenic shock, and overt cardiac failure (see WARNINGS). **Bendroflumethiazide** — Anuria, and in those with previous hypersensitivity to bendroflumethiazide or other sulfonamide-derived drugs.

WARNINGS: Nadolol — Cardiac Failure — Sympathetic stimulation may be a vital component supporting circulatory function in patients with congestive heart failure, and its inhibition by beta-blockade may precipitate more severe failure. Although beta-blockers should be avoided in overt congestive heart failure, if necessary, they can be used with caution in patients with a history of failure who are well compensated, usually with digitalis and diuretics. Beta-adrenergic blocking agents do not abolish the inotropic action of digitalis on heart muscle. IN PATIENTS WITHOUT A HISTORY OF HEART FAILURE, continued use of beta-blockers can, in some cases, lead to cardiac failure. Therefore, at the first sign or symptom of heart failure, digitalize and/or give diuretics, and closely observe response, or discontinue nadolol (gradually, if possible).

Exacerbation of Ischemic Heart Disease Following Abrupt Withdrawal — Hypersensitivity to catecholamines has been observed in patients withdrawn from beta-blocker therapy; exacerbation of angina and, in some cases, myocardial infarction have occurred after *abrupt* discontinuation of such therapy. When discontinuing chronic use of nadolol, particularly in patients with ischemic heart disease, gradually reduce dosage over a 1- to 2-week period and carefully monitor the patient. Reinstitute nadolol promptly (at least temporarily) and take other measures appropriate for management of unstable angina if angina markedly worsens or acute coronary insufficiency develops. Warn patients not to interrupt or discontinue therapy without physician's advice. Because coronary artery disease is common and may be unrecognized, it may be prudent not to discontinue nadolol therapy abruptly even in patients treated only for hypertension.

Nonallergic Bronchospasm (e.g., chronic bronchitis, emphysema) — PATIENTS WITH BRONCHOSPASTIC DISEASES SHOULD IN GENERAL NOT RECEIVE BETA-BLOCKERS. Administer nadolol with caution since it may block bronchodilation produced by endogenous or exogenous catechelamine stimulation of $beta_2$ receptors. **Major Surgery** — Because beta blockade impairs the ability of the heart to respond to reflex stimuli and may increase the risks of general anesthesia and surgical procedures, resulting in protracted hypotension or low cardiac output, it has generally been suggested that such therapy should be withdrawn several days prior to surgery. Recognition of the increased sensitivity to catecholamines of patients recently withdrawn from beta-blocker therapy, however, has made this recommendation controversial. If possible, withdraw beta-blockers well before surgery takes place. In emergency surgery, inform the anesthesiologist that the patient is on beta-blocker therapy. Use of beta-receptor agonists such as isoproterenol, dopamine, dobutamine, or levarterenol can reverse the effects of nadolol. Difficulty in restarting and maintaining the heart beat has also been reported with beta-adrenergic receptor blocking agents. **Diabetes and Hypoglycemia** — Beta-adrenergic blockade may prevent the appearance of premonitory signs and symptoms (e.g., tachycardia and blood pressure changes) of acute hypoglycemia. This is especially important with labile diabetics. Beta-blockade also reduces release of insulin in response to hyperglycemia; therefore, it may be necessary to adjust dose of antidiabetic drugs. **Thyrotoxicosis** — Beta-adrenergic blockade may mask certain clinical signs (e.g., tachycardia) of hyperthyroidism. To avoid abrupt withdrawal of beta-adrenergic blockade which might precipitate a thyroid storm, carefully manage patients suspected of developing thyrotoxicosis.

Bendroflumethiazide — Use with caution in severe renal disease. In patients with renal disease, azotemia may be precipitated. With impaired renal function, effects of the drug may be cumulative. Use with caution in impaired hepatic function or progressive liver disease, since minor alterations of fluid and electrolyte balance may precipitate hepatic coma. Sensitivity reactions may occur in patients with a history of allergy or bronchial asthma. Possibility of exacerbation or activation of systemic lupus erythematosus has been reported.

PRECAUTIONS: General — Nadolol — Use with caution in patients with impaired hepatic or renal function (see DOSAGE AND ADMINISTRATION).

Bendroflumethiazide — At appropriate intervals, perform serum electrolytes determination to detect possible electrolyte imbalance warning signs of which are dryness of mouth, thirst, weakness, lethargy, drowsiness, restlessness, muscle pains or cramps, muscular fatigue, hypotension, oliguria, tachycardia, and G.I. disturbances such as nausea and vomiting. Observe patients for clinical signs of fluid or electrolyte imbalance; namely, hyponatremia, hypochloremic alkalosis, hypokalemia. Serum and urine electrolyte determinations are particularly important when the patient is vomiting excessively or receiving parenteral fluids. Drugs such as digitalis may influence serum electrolytes. Hypokalemia may develop, especially with brisk diuresis, in presence of severe cirrhosis. Interference with adequate oral electrolyte intake will also contribute to hypokalemia. Response of the heart to toxic effects of digitalis can be exaggerated with hypokalemia. Use potassium supplements such as high potassium foods to avoid or treat hypokalemia. Any chloride deficit is generally mild and usually does not require specific therapy except under extraordinary circumstances (as in liver or renal disease). Dilutional hyponatremia may occur in edematous patients in hot weather; appropriate therapy is water restriction rather than salt administration except in rare instances when the hyponatremia is life threatening. In actual salt depletion, appropriate replacement is the therapy of choice.

Hyperuricemia may occur or frank gout may be precipitated in certain thiazide-treated patients. Latent diabetes mellitus may become manifest during thiazide therapy. Antihypertensive effects of bendroflumethiazide may be enhanced in the postsympathectomy patient.

Careful reappraisal of therapy and consideration given to withholding or stopping diuretic therapy is necessary if rising nonprotein nitrogen or BUN (indicative of progressive renal impairment) occurs. Thiazides may decrease serum PBI levels without signs of thyroid disturbance. Thiazides decrease calcium excretion. Pathologic changes in parathyroid gland with hypercalcemia and hypophosphatemia have been occasionally observed with prolonged therapy. Common complications of hyperparathyroidism have not been seen.

Information for Patients — Warn patients, especially those with evidence of coronary artery insufficiency, against interruption or discontinuation of nadolol without physician's advice. Although cardiac failure rarely occurs in properly selected patients, advise patients being treated with beta-adrenergic blocking agents to consult physician at the first sign or symptom of impending failure. Advise patients of proper course if dose inadvertently missed.

Laboratory Tests — Regularly monitor serum and urine electrolyte levels (see WARNINGS, *Bendroflumethiazide*, and PRECAUTIONS, *General, Bendroflumethiazide).*

Drug Interactions — Nadolol — When administered concurrently the following drugs may interact with beta-adrenergic blocking agents: **Anesthetics, general** — exaggeration of anesthetic-induced hypotension (see WARNINGS, *Nadolol, Major Surgery).* **Antidiabetic drugs (oral agents and insulin)** — hypoglycemia or hyperglycemia; adjust antidiabetic drug dosage accordingly (see WARNINGS, *Nadolol, Diabetes* and *Hypoglycemia).* **Catecholamine-depleting drugs (e.g., reserpine)** — additive effect; monitor closely for evidence of hypotension and/or excessive bradycardia.

Bendroflumethiazide — When administered concurrently the following drugs may interact with thiazide diuretics: **Alcohol, barbiturates, or narcotics** — may potentiate orthostatic hypotension. **Antidiabetic drugs (oral agents and insulin)** — thiazide-induced hyperglycemia may require adjustment of antidiabetic drug dosage. **Other antihypertensive drugs** — additive or potentiated effect. **Corticosteroids, ACTH** — intensified electrolyte depletion, particularly hypokalemia. **Ganglionic or peripheral adrenergic blocking drugs** — potentiated effect. **Preanesthetic and anesthetic agents** — effects may be potentiated; adjust dosage accordingly. **Pressor amines (e.g., norepinephrine)** — possible decrease response but not sufficient to preclude their use. **Skeletal muscle relaxants, nondepolarizing (e.g., tubocurarine)** — possible increased response.

Drug/Laboratory Test Interactions — Discontinue thiazides before tests for parathyroid function (see PRECAUTIONS, *General, Bendroflumethiazide).*

Carcinogenesis, Mutagenesis, Impairment of Fertility — Nadolol — In 1 to 2 years oral toxicologic studies in mice, rats, and dogs, nadolol did not produce significant toxic effects. In 2-year oral carcinogenic studies in rats and mice, nadolol did not produce neoplastic, preneoplastic, or nonneoplastic pathologic lesions. **Bendroflumethiazide** — Long-term studies in animals have not been performed.

Pregnancy — Teratogenic Effects — Nadolol — Category C. In animal reproduction studies with nadolol, evidence of embryo- and fetotoxicity was found in rabbits, but not in rats or hamsters, at doses 5 to 10 times greater (on a mg/kg basis) than the maximum indicated human dose; no teratogenic potential was seen in any of these species. There are no well-controlled studies in pregnant women; therefore, use nadolol in pregnant women only if potential benefit justifies potential risk to the fetus. **Bendroflumethiazide** — Category C. Animal reproduction studies have not been conducted. This drug's effect on the fetus when administered to a pregnant woman or its effect on reproductive capacity is not known. Bendroflumethiazide should be given to a pregnant woman only if clearly needed. **Nonteratogenic Effects** — Since thiazides cross the placental barrier and appear in cord blood, weigh anticipated benefit of the drug in pregnant women against possible hazards to the fetus; these hazards include fetal or neonatal jaundice, thrombocytopenia, and possibly other reactions which have occurred in adults.

Nursing Mothers — Both nadolol and bendroflumethiazide are excreted in human milk. Because of the potential for serious adverse reactions in nursing infants either discontinue nursing or discontinue therapy, taking into account the importance of CORZIDE (Nadolol-Bendroflumethiazide Tablets) to the mother.

Pediatric Use — Safety and effectiveness in children have not been established.

ADVERSE REACTIONS: Nadolol — Most adverse effects have been mild and transient and have rarely required nadolol withdrawal. **Cardiovascular** — Bradycardia with heart rates of less than 60 beats per minute occurs commonly, and heart rates below 40 beats per minute and/or symptomatic bradycardia were seen in about 2 of 100 patients. Symptoms of peripheral vascular insufficiency, usually of the Raynaud type, have occurred in approximately 2 of 100 patients. Cardiac failure, hypotension, and rhythm/conduction disturbances have each occurred in about 1 of 100 patients. Single instances of first degree and third degree heart block have been reported; intensification of AV block is a known effect of beta-blockers (see also CONTRAINDICATIONS, WARNINGS, and PRECAUTIONS). **Central Nervous System** — Dizziness or fatigue reported in approximately 2 of 100 patients; paresthesias, sedation, and change in behavior reported in approximately 6 of 1000 patients. **Respiratory** — Bronchospasm reported in approximately 1 of 1000 patients (see CONTRAINDICATIONS and WARNINGS). **Gastrointestinal** — Nausea, diarrhea, abdominal discomfort, constipation, vomiting, indigestion, anorexia, bloating, and flatulence each reported in 1 to 5 of 1000 patients. **Miscellaneous** — Each of the following reported in 1 to 5 of 1000 patients: rash; pruritus; headache; dry mouth, eyes, or skin; impotence or decreased libido; facial swelling; weight gain; slurred speech; cough; nasal stuffiness; sweating; tinnitus; blurred vision. Although relationship to drug usage is not clear, sleep disturbances have been reported. The oculomucocutaneous syndrome associated with practolol has not been reported with nadolol. The following adverse reactions may also occur: **Central Nervous System** — reversible mental depression progressing to catatonia; visual disturbances; hallucinations; an acute reversible syndrome characterized by disorientation for time and place, short-term memory loss, emotional lability with slightly clouded sensorium, decreased performance on neuropsychometrics. **Gastrointestinal** — mesenteric arterial thrombosis; ischemic colitis. **Hematologic** — agranulocytosis; thrombocytopenic or nonthrombocytopenic purpura. **Allergic** — fever combined with aching and sore throat; laryngospasm; respiratory distress. **Miscellaneous** — reversible alopecia; Peyronie's disease; erythematous rash; arterial insufficiency.

Bendroflumethiazide — Gastrointestinal System — anorexia, gastric irritation, nausea, vomiting, cramping, diarrhea, constipation, jaundice (intrahepatic cholestatic jaundice), pancreatitis. **Central Nervous System** — dizziness, vertigo, paresthesia, headache, xanthopsia. **Hematologic** — leukopenia, agranulocytosis, thrombocytopenia, aplastic anemia. **Dermatologic-Hypersensitivity** — purpura, photosensitivity, rash, urticaria, necrotizing angiitis (vasculitis, cutaneous vasculitis). **Cardiovascular** — orthostatic hypotension may occur. **Other** — hyperglycemia, glycosuria, occasional metabolic acidosis in diabetics, hyperuricemia, allergic glomerulonephritis, muscle spasm, weakness, restlessness. Whenever adverse reactions are moderate or severe, thiazide dosage should be reduced or therapy withdrawn.

OVERDOSAGE: Nadolol may cause excessive bradycardia, cardiac failure, hypotension, or bronchospasm if overdosed. Overdosage of thiazides may cause lethargy, which may progress to coma within a few hours, with minimal depression of respiration and cardiovascular function and without evidence of serum electrolyte changes or dehydration. Gastrointestinal irritation and hypermotility may occur. Transitory increase in BUN and serum electrolyte changes may occur, especially in patients with renal impairment.

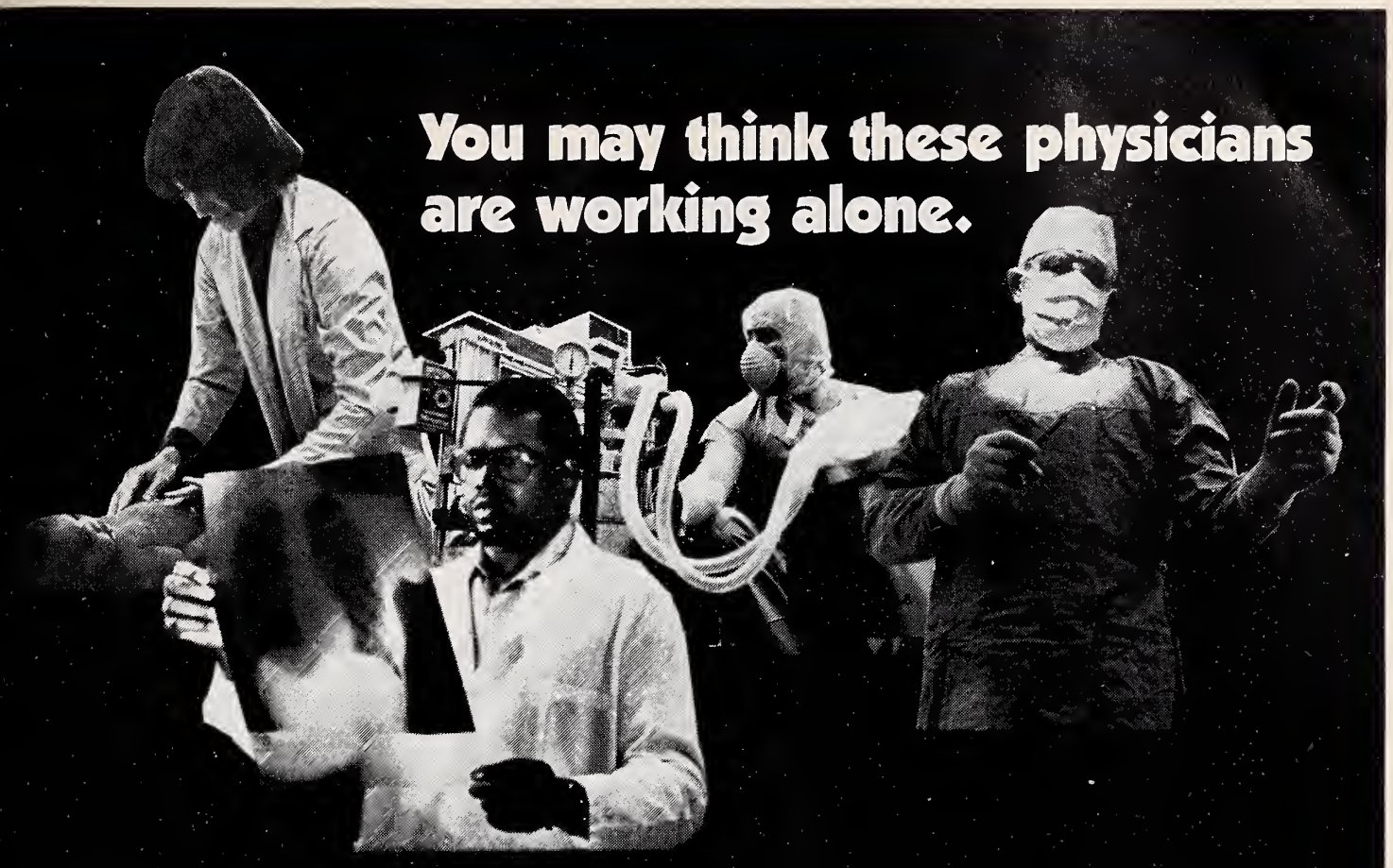
Treatment — Nadolol can be removed from the general circulation by hemodialysis. In determining duration of corrective therapy, take note of the long duration of the effect of nadolol. In addition to gastric lavage, employ the following measures, as appropriate. **Excessive Bradycardia** — Administer atropine (0.25 to 1.0 mg). If there is no response to vagal blockade, administer isoproterenol cautiously. **Cardiac Failure** — Administer a digitalis glycoside and diuretic. It has been reported that glucagon may also be useful in this situation. **Hypotension** — Administer vasopressors, e.g., epinephrine or levarterenol. (There is evidence that epinephrine may be the drug of choice.) **Bronchospasm** — Administer a $beta_2$-stimulating agent and/or a theophylline derivative. **Stupor or Coma** — Supportive therapy as warranted. **Gastrointestinal Effects** — Symptomatic treatment as needed. **BUN and/or Serum Electrolyte Abnormalities** — Institute supportive measures as required to maintain hydration, electrolyte balance, respiration, and cardiovascular and renal function.

DOSAGE AND ADMINISTRATION: DOSAGE MUST BE INDIVIDUALIZED. Patients with renal failure require adjustment in dosing interval; see package insert for dosage in these patients.

Consult package insert before prescribing CORZIDE (Nadolol-Bendroflumethiazide Tablets).

HOW SUPPLIED: Available as scored tablets containing 40 mg nadolol combined with 5 mg bendroflumethiazide and 80 mg nadolol combined with 5 mg bendroflumethiazide in bottles of 100.

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You may think these physicians are working alone.

But they really have a team behind them.

These physicians spend most of their day working independently in a one-to-one doctor/patient relationship. And chances are that as a physician, you do too.

But even though you can't see it, there's a strong team supporting and protecting the medical profession, affecting your practice while you see patients, research new drugs or perform surgery. That team consists of *your medical societies*.

The American Medical Association and your state and county medical societies believe in the value of teamwork; that only by working together can we, in the face of an increasingly complex professional environment, protect your right to make responsible decisions on how to practice medicine.

We also believe that all medical societies — county, state, and national — have certain tasks that the individual physician couldn't possibly assume — and shouldn't have to.

Tasks such as keeping government regulations from interfering with your practice by representing your interests at local and national levels. And challenging regulatory measures that threaten you and your patients' interests by mounting legal campaigns to defend your rights — up to the Supreme Court if necessary.

Why do we believe that *teamwork* means so much to *all* physicians — even those who work "alone"?

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Join Your Medical Societies Today.

For more information, contact your state or county medical societies, or call the AMA collect at 312/751-6196. Or return the coupon below to your state or county medical society.

☐ Please send me information on AMA, county, and state society membership.

☐ I am a member of my county and state societies; please send me information on joining the AMA.

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(404) 752-2376/3105

Report of Reference Committee F

Cyler D. Garner, M.D., Gordon, Chairman
C. Peter Lampros, M.D., Toccoa, Vice Chairman

In addition to the Chairman and Vice Chairman named above, the following persons served on Reference Committee F: C. Emory Johnson, MD, Macon; Archie J. Morris, MD, Vidalia; Luther M. Thomas, MD, Augusta; Hugo S. Moreno, MD, East Point; Marvyn D. Cohen, MD, Columbus; and Roland S. Summers, MD, Savannah.

President

William W. Moore, Jr., M.D.

While agonizing about how to summarize the events of the past 11 months, the words "fitness report" erupted up from my memories of time spent with the Naval forces. Like it or not, we need a fitness report from time to time to serve as a bench mark, to goad us toward improvement, and to satisfy us regarding specific achievements.

I think we have had a fair balance during the past year: the good things we have accomplished are balanced by problems that were met poorly or are yet unsolved.

To our credit, I honestly feel that Operation Care, our Legislative Conference at Amelia Island, the Medical-Legal Seminar, the Leadership Conference, the results obtained during the recent session of the Georgia Legislature, and our action regarding the voluntary freezing of physicians' fees for one year constitute genuinely good marks. My heart is filled with appreciation and warm feelings for the many, many people within our staff and among our colleagues whose time and efforts brought these things to fruition.

Additional good marks are deserved for our Scientific Assembly and other efforts in the field of continuing medical education; for the improved avenues of communication between ourselves and a variety of state agencies; and for the work done by the Maternal and Infant Health Committee and Task Force and the exciting program about to begin in an effort to impact on the related problems of teenage pregnancy and infant mortality. The recognition of our committee system and the continuing improvement in our communications with our membership through the MAG *Newsletter* and *Journal* deserve recognition.

There is, however, another side of the coin. We have problems that to date have been poorly, inadequately or not yet met. I cannot help but feel a sense of inadequacy, frustration, and disappointment that I have to leave these problems to my successor, Bill Clark, to work toward their ultimate solution. The overriding problem is that of bringing back together our MAG family which includes ourselves, GaMPAC, MAG Mutual, and the Georgia Medical Care Foundation. In the order mentioned, we have failed to support GaMPAC honorably and to a degree that would allow it to function adequately on our behalf. The percentage of our membership giving either minimal or meaningful financial support is pitiful. When viewed against their accomplishments despite limited means, I think we have to make a strong case for child neglect. The MAG Mutual situation is entirely different. We have given it exceptionally good support. It has flourished and, indeed, to the point of outgrowing our ability to sustain its growth and development. To the degree to which we were unable to predict and plan for the sustenance of this burgeoning growth, we have been likewise negligent, but perhaps the apex of our deficiencies lies in our relationships with the Foundation. Here is an organization that we founded to insure that doctors, not clerks and bureaucrats, would direct the medical review process. We have not only been unable to provide adequate support but we also have evolved into a frustrating situation of having to possibly support a further separation rather than a coming together of our organization in order to keep it functional and competitive.

All told, I have had a serious foreboding of this process of our family and a very strong desire to reverse that process and to bring our family together spiritually and financially.

To that end, we undertook the painful process of reviewing our Association operations and made the decision that we needed and would get a higher level of administrative efficiency and function and that we would seek as much as possible to correct and improve those aspects of our operations that have contributed to these problems.

There are additional problems related to those noted above. One that I am sure will occupy a major segment of our Annual Session is the financing of our organization and the dues structure. We have been 7 years without a dues increase, and times have changed considerably in that period. There will necessarily be many differing viewpoints to be considered in hammering out a satisfactory answer.

Our endorsed membership insurance program, which I consider to be the finest available for physicians in the country, is threatened, I believe, by a proposal to remove exclusive endorsement and to endorse multiple insurance schemes as they come along. I have serious concerns about the maintenance of credibility and value of our endorsement and more serious concerns about the effect on participation and the continuing enlistment of our newer and younger members in the program that is so essential to the continued maintenance of a strong and progressive program. We went through the embarrassment and difficulties of a failing insurance program in the mid 1970s, and I certainly hope that we will not let ourselves get into that position again.

Regarding membership, there are between 7,000 and 9,000 physicians in Georgia licensed to practice, and 5,600 of these are MAG members. We need continued and expanding efforts to gain the participation and support of those nonmembers who benefit from MAG without contributing to our efforts.

By the time this article is published, I am hopeful that we will have chosen and installed a new Executive Director and that we will have made significant progress in accommodating the needs of the Foundation to function in a rapidly changing climate of medical review needs.

I am very grateful for the hard work of our staff, our committees, our members, and our auxiliary that have kept our fitness report in some semblance of balance. I would earnestly ask you to recognize the problems of the

Association and to redouble your efforts to help Bill Clark and your other officers to deal with these problems during the coming year.

Thank you for 1983-84. You have given me a great present, and I very much appreciate it.

House Action

Filed the report.

Immediate Past President

Charles D. Hollis, Jr., M.D.

It has been stimulating to observe the continuing work and progress of the Medical Association of Georgia from the more relaxed and less responsible position of Immediate Past President. It makes one feel humble and appreciative to realize how much is being contributed in time, dedication, and effective performance by our colleagues in leadership roles towards the well-being of the profession and of our entire society. One wonders what impact physicians would have on the evolution of medicine and politics in this country if apathy could be dispelled and a majority became involved in solving the problem at hand.

During the year 1983-1984 it was my responsibility to:

1. Attend MAG Executive Committee and Board Meetings;
2. Serve on President Bill Moore's Ad Hoc Committee on Administration, a committee faced with intensive study and difficult decisions in finding ways to improve the efficiency of MAG operations;
3. Participate in Work Group I — Medical Science of the AMA's effort to establish a Health Policy agenda for the American people;
4. Work with Dr. Alvin Clair, MAG Advisor, the MAG staff, and the MAG Mutual staff in supporting educational and risk management seminars for the Georgia State Society of Medical Assistants;
5. Chair the Governor's Advisory Council on Medical Malpractice;
6. Continue as President of MAG Mutual — Georgia's Medical Society sponsored and physician-owned professional liability insurance company;
7. Attend the AMA annual and interim meetings as Delegate.

The development of the Health Policy Agenda for the American people, sponsored by the AMA in cooperation with representatives from the academic community, government, business, hospitals, nursing, labor, and the insurance industry is the most ambitious and potentially the most significant project ever undertaken by the AMA. In addition to Work Group I, there are five other work groups developing policy regarding education, health resources, delivery mechanisms, evaluation, assessment and control, and payment for services. The allocation of resources for education and research and principles affecting methods of practice, quality control, and physician income for the remainder of the 20th century will likely be determined by the decisions made by this group.

MAG Mutual Insurance Company, conceived and developed by MAG, has grown more rapidly than expected. About 2000 MAG members are now insured by MAG Mutual. Assets have risen to 13 million dollars and invested funds, yielding a return of 11.59%, have increased to 10.5 million. Actuaries, considering the very low expense ratio, recomended rates lower than those of the primary commercial carrier in Georgia for all eight classes of insureds. On average MAG Mutual's rates are 6-8% below comparable commercial rates this year.

The problems facing us in medicine now are of such magnitude that it will require the combined efforts of us all to make our influence felt. For this reason, I hope that the House of Delegates will move rapidly and aggressively in an effort to bring specialty society representatives, hospital medical staff officers, and residents under the MAG umbrella and more actively involved in the work of the organization.

In addition, I think we should find more effective ways to solicit help and utilize the considerable resources of the Auxiliary and medical assistants in working on our projects.

Last year, the House of Delegates approved the proposal that MAG develop a "road show" to travel to key areas of the state to indoctrinate young physicians in the ways in which MAG is working for them.

Recommendation

Implement immediately an indoctrination program for young physicians in cooperation with the staffs and officers of MAG Mutual, the Foundation for Medical Care, and GaMPAC, directing a portion of the program towards the Auxiliary and the medical assistants in each area.

House Action

Directed that the indoctrination program be referred to the appropriate committee for study and implementation.

Treasurer

James H. Sullivan, M.D.

The budget presented to the Finance Committee, Reference Committee F, the Executive Committee, and the Board of Directors for 1984-85 fiscal year amounts to $2,009,964 with a projected revenue income of $1,536,345. This leaves us an excess of expenses over income of $471,019 and a cash reserve position of approximately $814,733.

We have not had a dues increase since 1977, and in the seven years I have been treasurer we have seen expenses of the M.A.G. increase from $600,000 to $2,009,964. The dollar today is worth 59¢ of the 1977 dollar, due mainly to inflation. There's been no major organization that I know of that has not had a dues increase during this time.

Our services to the membership have greatly expanded, and we have had unforeseen problems legally to defend our right to the private practice of medicine. The Finance Committee, the Board of Directors, Reference Committee F, and the House of Delegates all voted to "hold the line" in 1983-84, but also agreed that a dues increase in 1984 might be appropriate and expected due to a continuing large deficit budget.

As Treasurer of the Medical Association of Georgia, the recommendation that I am going to make to refer to Reference Committee F is that of a dues increase. I'm requesting a dues increase of $125 total: $75 for fiscal year 1984-85; $25 for fiscal year 1985-86; $25, if necessary, for fiscal year 1986-87. I urge each of you as a

member of the House of Delegates to vote for this dues increase. Future increases may be rescinded if M.A.G. income improves or if the expenses decline.

For the second year in a row the budget has met the criteria which the House of Delegates in April of 1980 voted upon the recommendation of the President, Earnest C. Atkins, M.D., that "there should be no dues increase for M.A.G. members until the liquid, unrestricted funds of the Medical Association of Georgia are reduced to one half (½) of the amount budgeted for expenses in the year's budget under consideration, and that these funds be spent only by recommendation of the Finance Committee of the Board of Directors."

Attached to this report is a graph showing the budget from 1978-79 to 1984-85 projection. (Ed. Note, Contact Headquarters for a copy if desired.) I hope each of you will take time to review this and look at the figures. Last year in my report I predicted that if the rate of spending and the deficit budget continued that M.A.G. could be without funds in about three (3) years.

I have enjoyed my years of service with the Medical Association of Georgia, and along with L. B. Storey, (without whom I could not have functioned as a Treasurer), do not wish to leave the Association in a financial bind. It would not be fair to the new officers of the Medical Association of Georgia or the New Finance Committee. A poor cash position would limit any projects or services to the Association membership which are presently being provided. During my years as Treasurer of the Medical Association of Georgia, we have worked with and helped M.A.G. Mutual be born and seen it grow into a viable insurance company, the likes of which I think will lead the nation. The Georgia Medical Care Foundation has been aided by our Association.

Financially during the years I've been Treasurer we have seen the legislative effort intensify, and we have won many more battles than we have lost. The Doctor of the Day and the Physician Involvement Program have been essential in our breakthrough with the legislature. A medical doctor's presence at the Capitol during the legislature does make a difference.

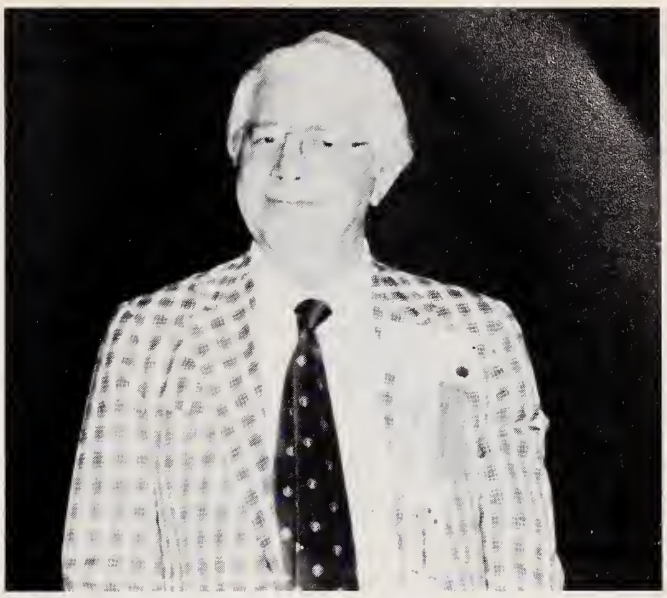
We have seen the *Journal* continue to show improvement, and it is a very definite service to our membership.

One of the great membership benefits is the *Newsletter* because it keeps each of us informed as to what is going on, facing many new problems, governmental and others, which we as physicians and our Association have to face every day. The *Newsletter* endeavors to make us aware of these problems and what our leaders advise doing about them.

We have seen the M.A.G. headquarters building beautifully remodeled with an elevator installed. In October 1984, we will pay our last note on this building.The neighborhood is improving, and the property value should be rising as the 10th Street Marta station is now in operation.

We have added word processors to help our staff do the best possible job and our Xerox which was purchased reproduces at 2¢ a page instead of 7.5¢ a page. The Public Relations Department of the Medical Association of Georgia has been given money for massive exposure of physician activities aimed at our patients and physician members in the future.

We are proud to have Mrs. John Bates (Glenda) of Cuthbert, Georgia, as President-Elect and President of the Auxiliary to the American Medical Association.



James H. Sullivan, M.D., Columbus, ended his 7 years of service as MAG's treasurer this year.

We have Dr. Bill Dowda on the Board of Trustees of the A.M.A., and Dr. Jack Rogers, presently Speaker of the House of the A.M.A., who is running unopposed for President-Elect of the A.M.A. in 1984. These are very good pluses for the State of Georgia and the practice of medicine.

We have aided the Auxiliary to the Medical Association of Georgia each year with its budget, and we have seen their membership and their projects prosper.

We have seen the tremendous rise in inflation during this time, with accompanying increase in local, state, and federal taxes, especially social security. We also see decreases in Medicare and Medicaid benefits, proof that our national politicians are capable of creating health care problems only and not solving them.

We have legally fought the Federal Trade Commission (FTC) with a tremendous amount of money, and we hope to come out favorably in our legal dealing with this body.

It has been a great pleasure to serve the Medical Association of Georgia as its Treasurer for the past seven years. I have met many friends and have kept many old ones. I would personally like to thank L. B. Storey for his dedication and attitude toward the Medical Association of Georgia and toward the financial assistance that he gives your Treasurer.

I would like at this time to thank the present and past Finance Committees, the present and past Executive Committees, the present and past members of Reference Committee F, the present and past members of the Board of Directors, and the entire membership of the Medical Association of Georgia for their help in keeping M.A.G. financially sound.

Recommendation

That the Medical Association of Georgia increase its membership dues by $125; $25 for fiscal year '84-'85, $25 for fiscal year '85-'86, and $25 for fiscal year '86-'87.

House Action

Adopted with an amendment that MAG increase its membership dues by $75 to be implemented in 1984-85.



(L to R) Drs. Alvin H. Clair, Atlanta, and Hugo S. Moreno, East Point, delegates to the 1984 House.

The House anticipates a possible increase of $25 can be expected in the 1985-86 and 1986-87 House of Delegates.

The Board of Directors was directed to investigate semi-annual billing with the local medical societies, and that the M.A.G. delegates to the AMA to investigate semi-annual billing at the AMA House of Delegates in June, 1984, reporting back to the Board of Directors in September, 1984. The House believes that a smaller dues statement will be more palatable to members and ease the burden of the dues increase.

Chairman of the Board of Directors

Joe L. Nettles, M.D.

Income	*1984-1985 Proposed Budget*	*Actual '83-'84 Estimated to May 31*
Membership Dues	$1,391,245	$1,001,230
Advertising Sales, *Journal*	101,000	96,380
Risk Management Seminars	8,000	16,800
Educational Seminars	4,000	12,611
GTE	00	00
MAG Leadership Conference	10,000	00
Subscriptions, *Journal*	6,500	6,300
Subscriptions, Newsletter	00	6
AMA Refund	6,500	7,200
Data Processing Fees	303,000	198,200
Interest Income	72,000	72,513
Rental Income	3,500	20,054
Miscellaneous Income	50,600	21,830
Physician Placement	2,300	2,300
Total Income	$1,958,645	$1,455,424
Excess Expenses	123,783	413,315
Total	$2,082,428	$1,868,739

Expenses

Administrative	*Proposed Budget*	*Actual '83-'84 Estimated to May 31*
Salaries	$615,861	$542,095
Health Insurance	50,315	46,880
Disability Insurance	4,745	4,560
FICA Tax	36,147	28,535
Unemployment Tax, State	807	2,240
Unemployment Tax, Federal	1,008	1,512
Retirement	31,700	29,984
Recruitment	00	00
Legal Fees	30,000	56,186
Legal Expense	750	1,716
WATS — Outward	5,500	5,500
WATS — Inward	7,800	7,100
Telephone	30,000	26,800
Postage	28,000	24,048
Staff Travel	26,000	25,810
Printing	2,700	1,906
Dues & Subscriptions	2,000	1,897
Data Base Maintenance	00	8,000
Audit	5,500	5,000
Office Supplies	12,000	10,570
Xerox Maintenance	2,500	2,245
Payroll Charge — Computer	00	1,200
Retirement Trust Fee	1,000	980
Labels — Computer	00	1,000
Car Allowance — Executive Director	00	2,784
Equipment Maintenance	10,000	8,120
Consultant — Legislative	00	00
Total Administrative	$904,333	$846,668

Membership	*Proposed Budget*	*Actual '83-'84 Estimated to May 31*
Travel — President	$ 4,000	$ 5,489
Travel — President-Elect	3,200	2,193
Travel — Past President	1,500	3,015
Travel — AMA Delegates	32,056	20,743
Caucus Breakfasts	1,800	1,851
Headquarters Suite	3,800	3,950
Southeastern Coalition	2,900	2,083
Travel, Sec. & Treasurer to AMA	5,100	2,012
2 MD's to AMA Leadership Conference	1,500	1,260
AMA MSS — Annual Session	1,000	00
AMA MSS — Travel	2,740	2,269
State Medical Education Luncheon	375	367
Sundry	600	481
Executive Committee Provisional	6,000	00
Executive Committee Travel	6,000	5,080
Business Coalition	4,000	4,000
Meetings	5,000	5,035
President's Provisional Fund	24,000	22,800
Roster	10,000	9,515
Proceedings Issue	3,000	3,000
Total	$118,571	$95,143

Building Expenses	Proposed Budget	Actual '83-'84 Estimated to May 31
Interest on Mortgage	$ 335	$ 5,124
Building Maintenance	7,500	19,740
Janitorial Service	16,600	15,800
Insurance — Casualty	6,500	7,003
Utilities	32,000	34,009
Depreciation — Building	22,300	22,300
Depreciation — Equipment	27,828	27,828
Ad Valorem Tax	23,590	15,069
Total	$136,653	146,873

Journal		
Salaries	$ 36,311	$ 35,750
Health Insurance	5,892	3,438
FICA	2,192	2,128
Retirement	2,300	2,180
Printing	68,000	60,010
Photo Processing	200	380
Advertising — Promotion	300	00
Postage — Copyright	7,900	7,080
Clipping Service	450	410
Dues, Subscriptions	200	130
Artwork	3,700	2,920
Mailing Labels	650	450
Travel	800	1,162
Total	$128,895	$116,038

Information Systems	Proposed Budget	Actual '83-'84 Estimated to May 31
Salaries	$123,501	$ 90,144
FICA	8,645	5,836
Health Insurance	13,690	9,422
Retirement	3,628	5,002
Insurance, Equipment	600	500
Equipment Rental	48,149	52,941
Equipment Maintenance	25,878	20,930
Data Communication	2,434	2,235
Service Contracts	2,400	6,262
Supplies — Durable	2,500	2,004
Supplies — Expendable	8,000	9,543
Softwear — Documentation	41,800	340
Installation & Site Prep.	29,235	00
Depreciation — Equipment	26,000	24,000
Travel	2,200	1,793
Education, Dues Subscriptions	4,700	613
Consulting Fees	600	650
Temporary Help	400	00
Recruitment	2,550	00
Office Operation	5,645	1,463
Total	$352,555	$233,678

Other	Proposed Budget	Actual '83-'84 Estimated to May 31
Retainer — Franklin	$ 3,600	$ 3,600
AAMA President Gift — Mrs. Bates	00	00
Board of Directors Contingent	140,000	159,200
Rogers Campaign	10,000	00
Total Other	$153,600	$162,800

Committees & Specialty Societies		
Access to Health Care	$ 4,700	$ 2,872
Annual Session	15,185	14,852
Auxiliary	38,175	51,641
Cost Awareness	2,000	498
Doctor of Day Program	5,500	4,360
Impaired Physicians	63,000	58,500
Legislation & Bulletin	44,376	42,800
Physician Involvement Program	4,350	3,102
Health Planning	500	00
Education	4,500	4,774
Medical Aspects of Sports	200	00
Nutrition	00	00
Physician-Lawyer Liaison	4,950	85
Professional Liability Insurance	1,360	1,360
Public Relations	60,000	42,994
Scientific Assembly	10,125	10,538
Newsletter	11,900	11,380
Third Party Relations	6,250	00
Leadership Conference (MAG)	6,000	17,783
Computer Education	4,750	00
Total Committees	$ 287,821	$ 267,539
Total Expenses	$2,082,428	$1,868,739
Equipment Purchases	$172,105	

House Action

Adopted the 1984-85 budget with the following amendment: "that the Georgia Medical Care Foundation and the Medical Association of Georgia reach a mutually satisfactory agreement on the 'cost per discharge' today, April 27, and the contract be signed by the proper officer of each corporation."

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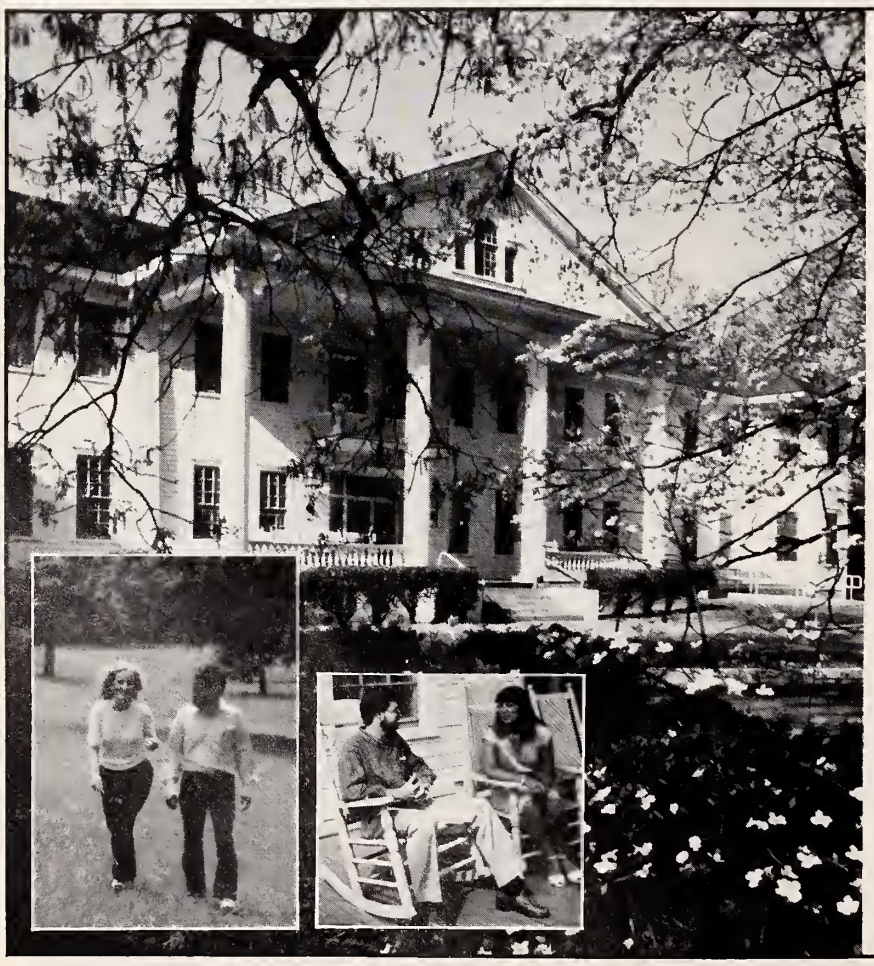
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MANUSCRIPTS — Articles are accepted for publication on the condition that they are contributed solely in this *Journal*. Manuscripts should be typewritten, double-spaced, and the original and one copy should be submitted. Receipt of manuscripts will be acknowledged and unused manuscripts returned. Used manuscripts will be returned only if requested.

STYLE — Ordinarily articles should not exceed 3,000 words. Only under exceptional circumstances will articles of over 4,000 words be published. Footnotes, bibliographies, and legends should be typed on separate sheets, double-spaced. Bibliographies should conform to the following style: name of author (with initials), title of article, name of periodical, date, volume (number, if available), and pages.

> Soter NA, Wasserman SI, Austen KF. Cold urticaria release into circulation of histamine and eosinophil chemotactic factor of anaphylaxis during cold challenge. N Engl J Med 1976;294:687-90.

NEWS NOTES — District and county medical societies, Association members, and readers are invited to send in any news items of general concern to members of the Medical Association of Georgia.

REPRINTS — Requests for reprints should be made directly to The Ovid Bell Press, Inc., 1201-05 Bluff Street, Fulton, Missouri 65251. Reprints must be ordered within 30 days after publication, since all type will be destroyed after that time.

ILLUSTRATIONS — Illustrations must be submitted in duplicate. Illustrations, tables, etc., should bear the author's name and figure number. Used photographs, drawings and cuts will be returned after publication only if requested. The cost of reproduction of illustrated material for publication in excess of three average illustrations and/or tables will be borne by the author, and the *Journal* will bill the author for this expense.

GENERAL POLICY — Authors will be given as wide a latitude as the general policy of the *Journal* and the demands on its space permit. The right to reduce, revise, or reject any material submitted for publication is always reserved. The *Journal* is not responsible for statements made by any contributor. All communications regarding editorial, advertising, subscription, and miscellaneous matters should be sent to The Editor, 938 Peachtree Street, N.E., Atlanta, GA 30309-3990.

ADVERTISING — All pharmaceutical advertising must be approved by the State Medical Journal Advertising Bureau, Inc., to be acceptable for publication. Other advertising copy may be accepted subject to the approval of the Editor. All copy or negatives must reach the *Journal* office by the 10th of the month preceding publication. General and classified advertising rates will be furnished on request.

MEDICAL EDITING SERVICE — If in the opinion of the *Journal* Editorial Board, material submitted for publication could be improved by a Medical Editing Service, the Editor will contact the author for his approval. Association members needing assistance in preparation of material for publication may also use this service. A reasonable charge is made for this service and the cost of this will be borne by the author.

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PHYSICIAN WANTED

Physicians interested in practice opportunities in the Southeast, please contact: Director, Physician Recruitment, Regional Health Service, Inc., P. O. Box 2345, Anniston, AL 36202 (205) 236-2907.

Psychiatrist: Georgia-St. Simons Island — General psychiatrist with inpatient experience to work with expanding group practice. High starting salary. Resort area with growing population. New 60-bed hospital. Reply to Box 4-B c/o *Journal*.

Retired or semi-retired family practice or internist to help with week-day and weekend work in my office and in the hospital. Send CV to: Occupant, 8115 S.W. 1st Place, Gainesville, FL 32605.

Emergency Medicine — Immediate openings for experienced emergency physicians 40 miles from Atlanta in ER with 19,000 visits per year. Starting pay 74K, 81K in 9 months. Send CV with references to Emergency Medicine, 4995 Dublin Dr., SW, Atlanta, GA 30331.

POSITION WANTED

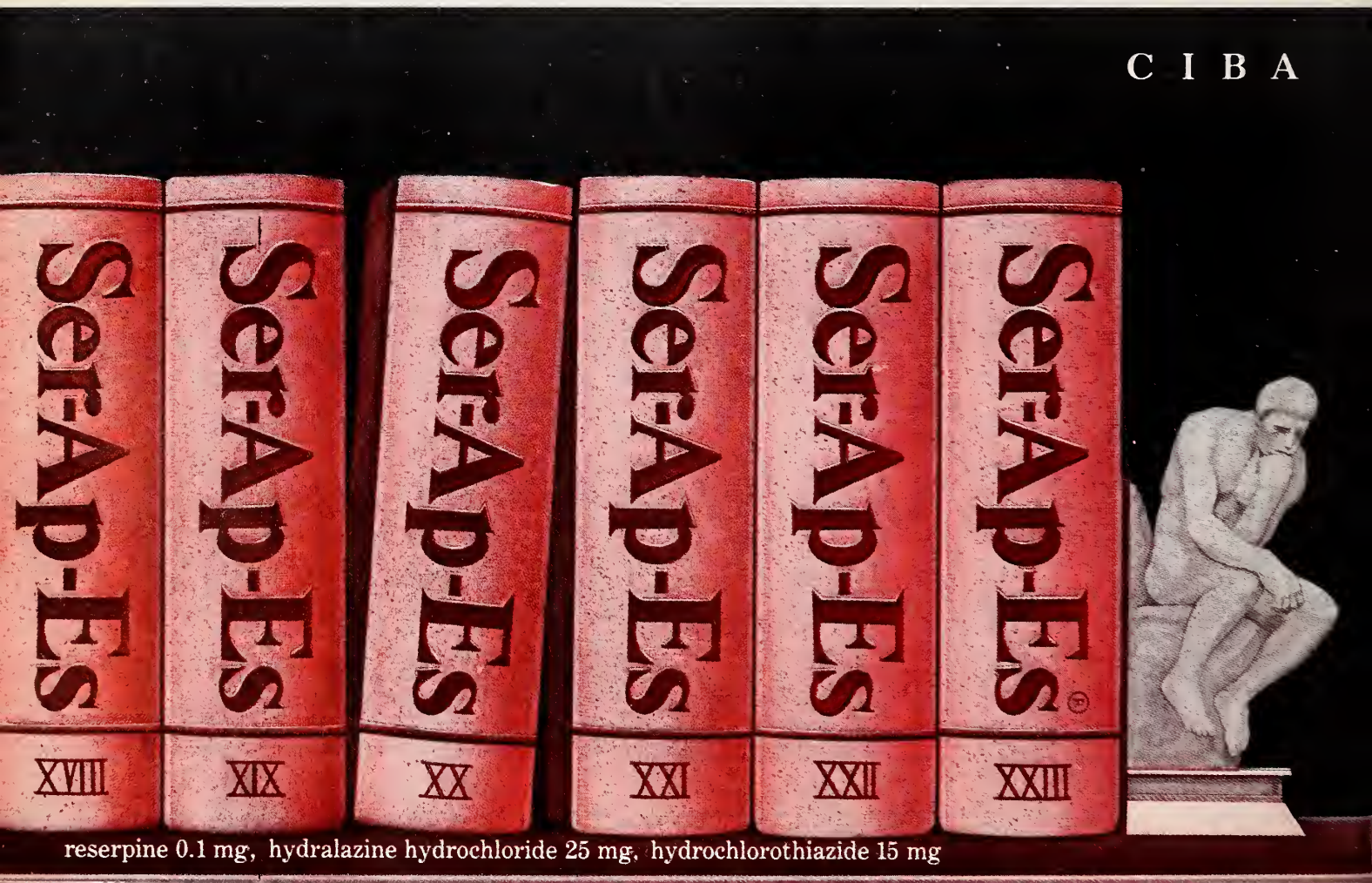
Cardiologist — Recent graduate; board certified, presently practicing but desires location in Southeast; catheterization & coronary angioplasty plus noninvasive skills; nuclear cardiology. Reply to Box 4-A, c/o *Journal*.

Medical Administrative Assistant — Desires Atlanta position. 13 years experience in assisting busy physicians in practice administration, patient care coordination, research for and preparation of academic presentations, coordination of local, state, and regional specialty organizations, medical/legal and medical/legislative concerns, and personal investment folios. Skilled in transcription, bookkeeping, and data processing. Reply to Box 6-A, c/o *Journal*.

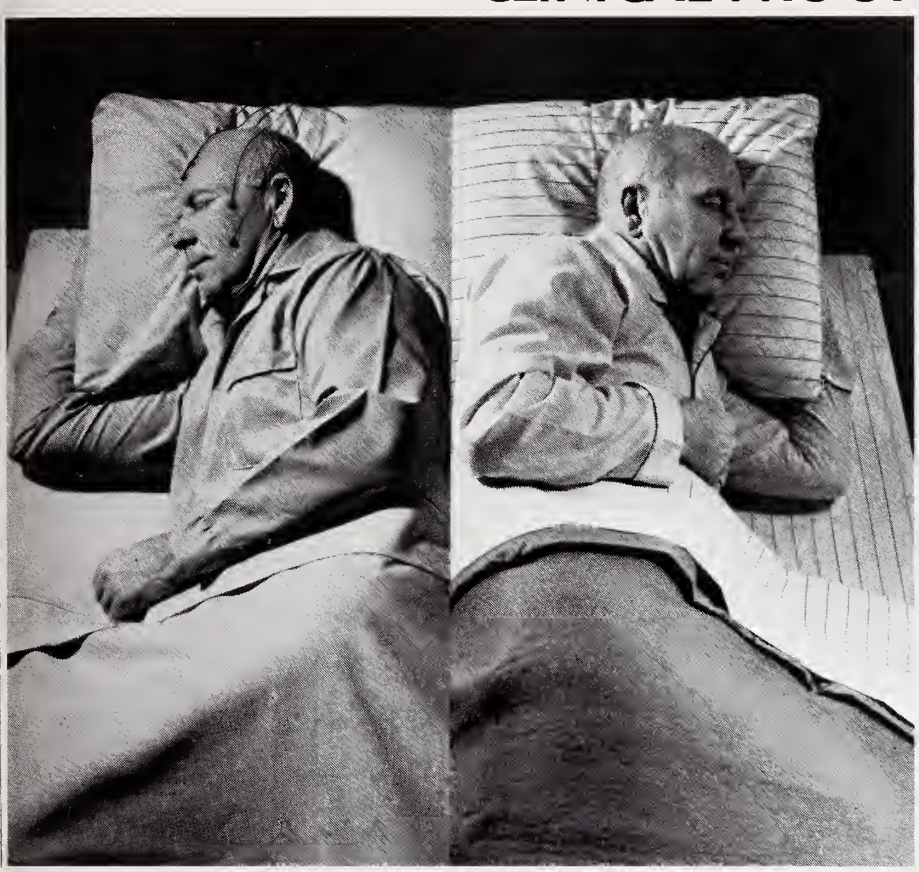
SERVICES

Virginia Heart Institute provides on-site consultation for administrators interested in the development of ambulatory facilities including outpatient cardiac catheterization. If interested, write Patricia Ferree at Virginia Heart Institute, 205 N. Hamilton St., Richmond, VA 23221.

RATES AND DATA: *Space in this section is sold on a per-word basis as follows:* **Members** — *$15 for the first 25 words; $.25 per word for each additional word.* **Non-members** — *$25 for the first 25 words; $.25 per word for each additional word.* Charges are payable in advance. *Copy must be typed and received by the Managing Editor no later than the 12th of the month preceding publication. Blind box numbers are available at an additional charge of $1 per insertion. For more information, contact* Journal *staff at 938 Peachtree St., NE, Atlanta, Ga 30309-3990, telephone (404) 876-7535. INWATS in Georgia (800) 282-0224.*



COMPLETE LABORATORY DOCUMENTATION[1-5]... EXTENSIVE CLINICAL PROOF



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DALMANE® ℣
flurazepam HCl/Roche

THE COMPLETE HYPNOTIC PROVIDES ALL THESE BENEFITS:

- Rapid sleep onset[1-6]
- More total sleep time[1-6]
- Undiminished efficacy for at least 28 consecutive nights[2-4]
- Patients usually awake rested and refreshed[7-9]
- Avoids causing early awakenings or rebound insomnia after discontinuation of therapy[2,5,10-12]

Caution patients about driving, operating hazardous machinery or drinking alcohol during therapy. Limit dose to 15 mg in elderly or debilitated patients. Contraindicated during pregnancy.

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flurazepam HCl/Roche

References: **1.** Kales J *et al*: *Clin Pharmacol Ther* 12:691-697, Jul-Aug 1971. **2.** Kales A *et al*: *Clin Pharmacol Ther* 18:356-363, Sep 1975. **3.** Kales A *et al*: *Clin Pharmacol Ther* 19:576-583, May 1976. **4.** Kales A *et al*: *Clin Pharmacol Ther* 32:781-788, Dec 1982. **5.** Frost JD Jr, DeLucchi MR: *J Am Geriatr Soc* 27:541-546, Dec 1979. **6.** Kales A, Kales JD: *J Clin Pharmacol* 3:140-150, Apr 1983. **7.** Greenblatt DJ, Allen MD, Shader RI: *Clin Pharmacol Ther* 21:355-361, Mar 1977. **8.** Zimmerman AM: *Curr Ther Res* 13:18-22, Jan 1971. **9.** Amrein R *et al*: *Drugs Exp Clin Res* 9(1):85-99, 1983. **10.** Monti JM: *Methods Find Exp Clin Pharmacol* 3:303-326, May 1981. **11.** Greenblatt DJ *et al*: *Sleep* 5(Suppl 1):S18-S27, 1982. **12.** Kales A *et al*: *Pharmacology* 26:121-137, 1983.

DALMANE® ℣
flurazepam HCl/Roche

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Effective in all types of insomnia characterized by difficulty in falling asleep, frequent nocturnal awakenings and/or early morning awakening, in patients with recurring insomnia or poor sleeping habits; in acute or chronic medical situations requiring restful sleep. Objective sleep laboratory data have shown effectiveness for at least 28 consecutive nights of administration. Since insomnia is often transient and intermittent, prolonged administration is generally not necessary or recommended. Repeated therapy should only be undertaken with appropriate patient evaluation.

Contraindications: Known hypersensitivity to flurazepam HCl; pregnancy. Benzodiazepines may cause fetal damage when administered during pregnancy. Several studies suggest an increased risk of congenital malformations associated with benzodiazepine use during the first trimester. Warn patients of the potential risks to the fetus should the possibility of becoming pregnant exist while receiving flurazepam. Instruct patient to discontinue drug prior to becoming pregnant. Consider the possibility of pregnancy prior to instituting therapy.

Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants. An additive effect may occur if alcohol is consumed the day following use for nighttime sedation. This potential may exist for several days following discontinuation. Caution against hazardous occupations requiring complete mental alertness (*e.g.*, operating machinery, driving). Potential impairment of performance of such activities may occur the day following ingestion. Not recommended for use in persons under 15 years of age. Though physical and psychological dependence have not been reported on recommended doses, abrupt discontinuation should be avoided with gradual tapering of dosage for those patients on medication for a prolonged period of time. Use caution in administering to addiction-prone individuals or those who might increase dosage.

Precautions: In elderly and debilitated patients, it is recommended that the dosage be limited to 15 mg to reduce risk of oversedation, dizziness, confusion and/or ataxia. Consider potential additive effects with other hypnotics or CNS depressants. Employ usual precautions in severely depressed patients, or in those with latent depression or suicidal tendencies, or in those with impaired renal or hepatic function.

Adverse Reactions: Dizziness, drowsiness, lightheadedness, staggering, ataxia and falling have occurred, particularly in elderly or debilitated patients. Severe sedation, lethargy, disorientation and coma, probably indicative of drug intolerance or overdosage, have been reported. Also reported: headache, heartburn, upset stomach, nausea, vomiting, diarrhea, constipation, GI pain, nervousness, talkativeness, apprehension, irritability, weakness, palpitations, chest pains, body and joint pains and GU complaints. There have also been rare occurrences of leukopenia, granulocytopenia, sweating, flushes, difficulty in focusing, blurred vision, burning eyes, faintness, hypotension, shortness of breath, pruritus, skin rash, dry mouth, bitter taste, excessive salivation, anorexia, euphoria, depression, slurred speech, confusion, restlessness, hallucinations, and elevated SGOT, SGPT, total and direct bilirubins, and alkaline phosphatase; and paradoxical reactions, *e.g.*, excitement, stimulation and hyperactivity.

Dosage: Individualize for maximum beneficial effect. *Adults:* 30 mg usual dosage; 15 mg may suffice in some patients. *Elderly or debilitated patients:* 15 mg recommended initially until response is determined.

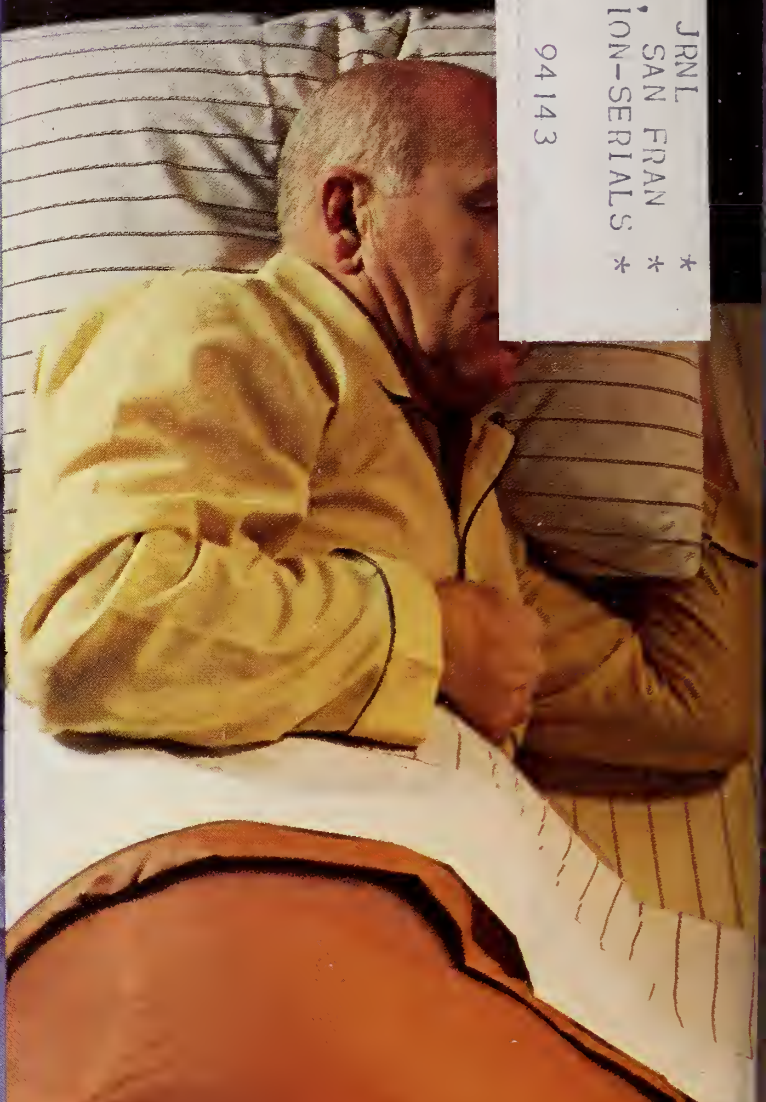
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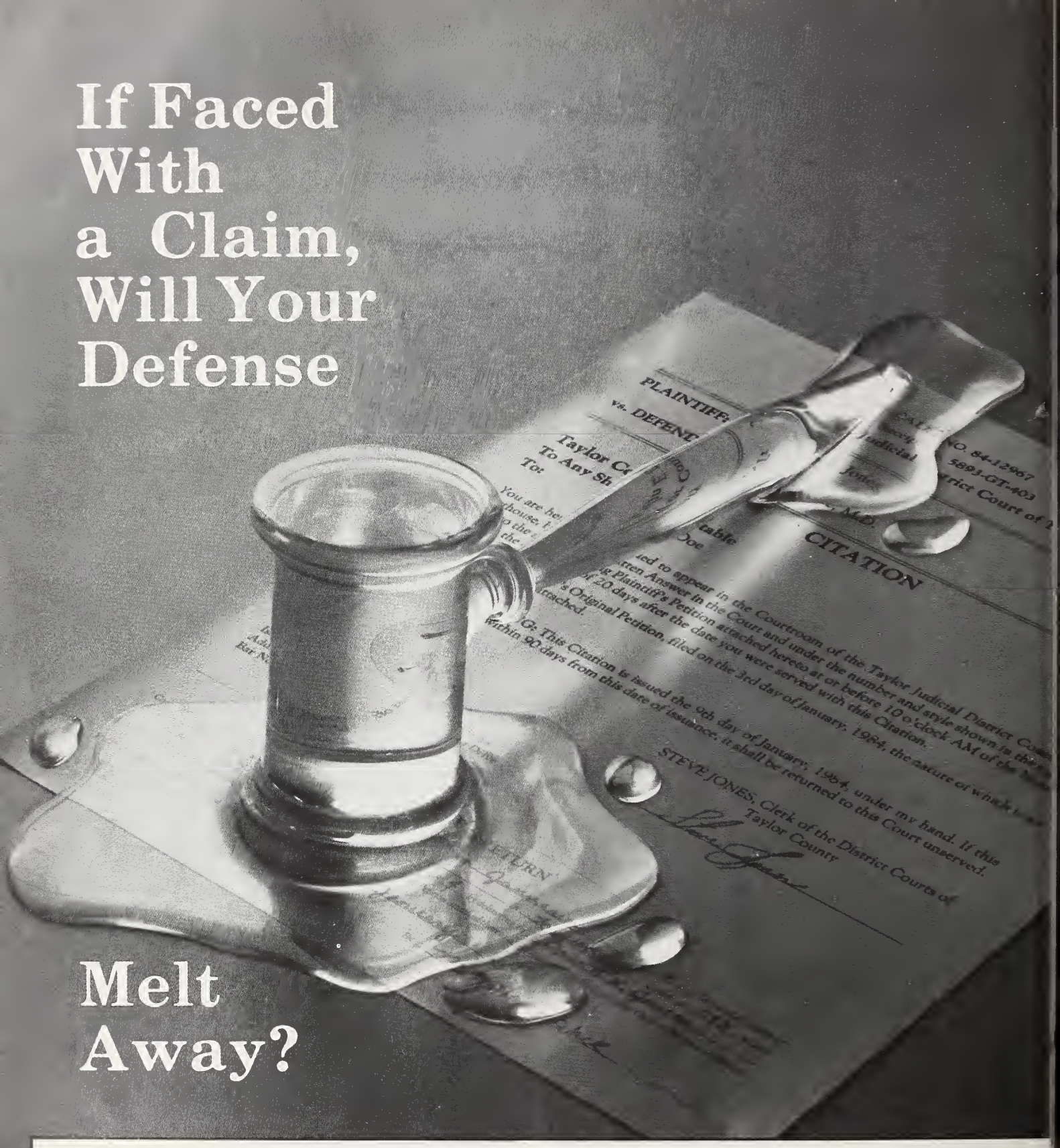
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And because the hospital is JCAH accredited and fully licensed, most major hospitalization insurance plans cover treatment.

If you have a patient who may need psychiatric hospitalization, call toll free. Our medical director, Roger Jay Pentzien, M.D., is available 24 hours to take your call.

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Established 1911. Owned and edited by the Medical Association of Georgia. Published monthly under the direction of the Board of Directors of the Association. Printed by The Ovid Bell Press, Inc., Fulton, Missouri.

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The subscription price per year for members of the Medical Association of Georgia is $7.50, included in the annual membership dues. The subscription price for nonmembers is $15.00 in the United States, Canada and Mexico, and $17.00 in other countries. Single copies are $2.

The *Journal of the Medical Association of Georgia* is published monthly at 938 Peachtree Street, N. E., Atlanta, GA 30309-3990. Second-class postage paid at Atlanta, Georgia, and at additional mailing offices. POSTMASTER: Send address changes to Medical Association of Georgia, 938 Peachtree Street, N. E., Atlanta, GA 30309-3990.

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THE COVER

Our cover photo this month was taken by Chuck Rogers, Jr., an Atlanta photographer, at the 1979 Peachtree Road Race.

Incidental Intelligence . . .

AMA/APA Physician Mortality and Suicide Study

In response to resolutions beginning in 1979 on physician suicide and physician mortality, the American Medical Association (AMA) coordinating with the American Psychiatric Association (APA) authorized a pilot study project in 1980 and 1981. This study included 24% of the U.S. physician population in Arizona, California, Michigan, Oregon, and Pennsylvania. The information was obtained by psychiatrists within District Branches of the APA interviewing willing survivors with confidentiality to be respected and as part of the agreement. A thorough analysis of the information is available in Report: G(I-82) of the AMA Council on Scientific Affairs. Studies dating back to 1912 indicated the physician suicide rate was between 30-40 per 100,000 population. The pilot project results indicated that the extrapolated physician suicide rate for 1980-81 was 19.5 — 28.4 per 100,000. The national rate for the entire U.S. population in 1980 was estimated to be 12.7 per 100,000. With certain adjustments, the physician suicide rate continued to be estimated to be 3 times the national population rate.

Many selected characteristics of physicians who died by suicide were compared to physicians who died by natural causes. Only a few of the characteristics studied will be mentioned here. No substantial differences were found in the use of alcohol or other drugs between the two groups except near the time of death. At that time, the suicide physicians were reported to have increased their drinking of alcoholic beverages. Both groups were described as "workaholics." A total of 86% of the suicides sustained personal and professional losses in the immediate past compared to none for the "natural" group. The suicide group was more likely to have been financially worried or have had the loss of their license or hospital affiliations. In the suicide group, the source of satisfaction was less frequently the family and more often recreation, especialy isolated recreation. Both groups were seen as practicing competently at the time of their death in about 50% of the cases, with 20% of the suicide group described as incompetent and none of the natural group seen as incompetent. Self-imposed isolation or overwork and overinvolvement were seen as coping mechanisms to deal with feelings of inadequacy and low self-esteem. The interviewers felt that 53% of the suicides were definitely foreseeable and 33% were possibly foreseeable. A total of 60% were seen as possibly preventable and 7% seen as highly preventable.

Recommendations from the pilot study by the AMA included extending the physician study through 1984, obtaining additional interviewers in order to build a large data base, and coordinating with the APA and selected volunteer psychiatrists in the District Branches to complete the interviews.

In 1984, the AMA coordinating with the APA developed a national study with purposes to include identifying factors that place physicians at risk for suicide, identifying factors that counteract lethality, identifying opportunities for prevention of suicide among physicians at risk, establishing and maintaining a repository of data bearing upon premature physician mortality, assessing the need for post-suicidal emotional support among surviving family members, and identifying areas for additional inquiry by the AMA, APA, and other organizations and/or individual researchers. An apparent continued goal from the pilot project and including the national project is to also enhance prevention through improved training of physicians. The national study is in progress, with the results to be published after the data are collected and analyzed.

Our grateful appreciation is expressed to the following individuals who served as volunteer interviewers in the AMA/APA Physician Mortality Project: David Bedell, M.D., Robert Clayton, M.D., Sheldon Cohen, M.D., John Curtis, M.D., Richard Fields, M.D., Steven Haney, M.D., John Herbert, M.D., Andy Hurant, M.D., Mark Hutto, M.D., Sidney Isenberg, M.D., and Harry Porter, M.D.

(Reported by W. Theron McLarty, M.D., P.C., Georgia Coordinator of AMA/APA Physician Mortality Project, Ridgeview Institute, Smyra, Georgia.)

Composite State Board of Medical Examiners' Disciplinary Actions

At the request of the Composite State Board of Medical Examiners (the "Board"), the Medical Association of Georgia has agreed to publish the results of disciplinary actions of the Board as a public service to inform physicians throughout the State of Georgia of the actions taken by the Board.

The disciplinary actions described below constitute the actions taken by the Board and are subject to appeal by the physicians involved to an appropriate superior court pursuant to the terms of the Georgia Administrative Procedure Act.

The following actions were taken between January 1 and March 31, 1984. The Board typically includes several provisions in an Order which are not summarized here. You are advised that you should not take any adverse action against a physician based on this report; you should request a copy of the public order from the Board, and evaluate that document before making any decisions affecting any of these physicians. This listing does not reflect pending appeals.

Disciplinary Actions/Consent Orders

Frank B. Clark, M.D., Austell, GA
Mario Machado, M.D., East Point, GA
Ralph B. Perkerson, Jr., M.D., Vidalia, GA
Ignatius Stein, M.D., College Park, GA
William E. Tryon, M.D., Marietta, GA

Licensure Action/Consent Order

Claude Ray Thomas, M.D., Richfield, UT

MAG Sponsors Child Restraint Billboard Campaign

On July 1, 1984, the Child Restraint law went into effect in the State of Georgia. This law requires that drivers who customarily transport children under the age of 4 in motor vehicles, restrain the child passengers through the use of either a seatbelt or an appropriate infant or child carseat, depending on the age of the child. Carpools and vehicles-for-hire are exempt from this law.

To help alert the public to this new law and to make them aware of the law's importance, the MAG has become involved in a statewide billboard campaign. Through the work of the Public Relations Committee and the Medicine and Human Values Committee, the MAG commissioned 140 billboards to be made for distribution throughout the state at a total cost of $3000.

We are appreciative of the Georgia Sheriff's Association who contacted the various companies inquiring about placement. The billboards are being mounted wherever there is public service space available. Turner Outdoor Advertising in Atlanta was responsible for the artwork design, distribution, and mounting at no charge. Southern National, Inc. printed the billboards. (Had these services not been donated, the cost would have been $98,000.)

The billboards are color designs of a man holding an infant in a carseat. Next to this drawing is the message:

CAR SEATS REDUCE CHILD DEATHS 90%

It's the Law — Effective July 1, 1984

A Message From the Medical Association of Georgia and the Georgia Sheriff's Association

MAG is also working with the Governor's Office of Highway Safety to alert OB/GYNs and pediatricians on ways to inform their patients of the child restraint law and to stress the law's importance in saving the lives of Georgia's children.

Medicare Goes HMO

Nearly 2 years after enactment of a law setting up a prospective payment option for Medicare HMO enrollees, the regulations to implement the law have been released by the U.S. Department of Health and Human Services. The new plan will cost the federal government nearly $100 million in its early years but long-range savings are expected.

The proposed regulations, which reportedly were delayed due to Office of Management and Budget cost concerns, were outlined at an HHS press conference May 22 and will be issued in final form this fall.

Under the proposal, HMOs, preferred provider organizations (PPOs), and other alternative delivery arrangements would have the option to continue under the cost-based arrangements most HMOs now have with Medicare; or they could move to a prospectively-determined, capitated payment.

Under prospective payment, Medicare would pay the HMO up to 95% of the adjusted average per capita cost for Medicare beneficiaries in the fee-for-service system. The new plans are expected to reduce or eliminate Medicare's current cost-sharing. Beneficiaries would continue to pay Medicare's monthly Part B premium, now at $14.60 a month, however, and could be charged a new monthly HMO premium as well. That premium is expected to vary from about $20 to $50 a month.

About 775,000 or 2.5% of all Medicare beneficiaries are now enrolled in HMOs. Most of these are in 21 demonstration plans where reimbursement is similar to that in the new regulations.

HHS Secretary Margaret Heckler predicted that another 600,000 Medicare beneficiaries would enroll in HMOs within the next 3 or 4 years. She said the new payment arrangement will "mean more complete medical coverage with lower out-of-pocket costs" for beneficiaries and "long-term savings for the Medicare program" as well. She acknowledged, however, that the plan is expected to cost Medicare about $30 million in its first year of operation and $65 million in the second. Indeterminate savings are anticipated in the third year of the plan.

New Drug Approvals

The Food and Drug Administration (FDA) approved a new antibiotic, cefonicid (Smith Kline & French Laboratories). Because it acts for up to five hours in the patient instead of minutes as do current antibiotics, a single daily injection works as well as four daily injections of current agents. If cefonicid catches on, and it will be widely advertised, it will cut the costs of administering antibiotics in hospitals and make more patients eligible for treatment as outpatients. This will have a major impact on health care costs — one study estimates that as much as $277 million could be cut from the nation's hospital bill if the drug is used sufficiently widely.

Cefonicid is only the first of what are likely to be a series of such long-acting antibiotics. Hoffman-La-Roche has applied to the FDA for approval for another, similar agent with an even longer action and a slightly different spectrum of antibacterial activity.

FDA is getting ready to approve the use of a kidney stone drug which will help prevent the formation of some types of kidney stones and thus avoid the need of surgery. The drug is potassium citrate (Urocit, Mission Pharmacal). It is one of the so-called orphan drugs although the studies leading to the pending approval were supported by NIH rather than by FDA.

Governor Receives History of Medical Profession



In honor of Doctors' Day 1984, the Auxiliary to the Medical Association of Atlanta presented to the Governor's Mansion Library a copy of the state auxiliary's new book, *The Medical Profession in Georgia, 1733-1983*. Governor Joe Frank Harris accepted the book in his office at the State Capitol from, left to right: Mrs. George R. Jones (Judy), from DeKalb County, President of the MAG auxiliary; Mrs. Brit B. Gay, Jr. (Evelyn), AMAA and AMAG member and author of the book; Mrs. Charles G. Rogers (Laura), Doctors' Day chairman for AMAA; and Mrs. Philip R. Bartholomew (Margaret) current president of the AMAA. MAG members may still order copies of the book by sending a check for $25 to the Auxiliary to MAG at 938 Peachtree St. NE, Atlanta, GA 30309. Revenues go to the state group's William R. Dancy M.D. Student Loan Fund for Georgia medical students, a project of the state auxiliary since 1930.



MEDICAL MEETING CALENDAR

JULY

23-25 — *Kiawah Island, SC:* **Pediatric Update — 1984.** AMA Category 1 and AAFP prescribed credit. Contact Div. of Cont. Ed., MCG, August 30912. PH: 404/828-3967.

26 — *Macon:* **Local Initiatives in Health Care Cost Containment.** Contact Gould Hagler, MAG, 938 Peachtree St., NE, Atlanta 30309. PH:404/876-7535 or 1-800-282-0224 (toll free in Ga.).

26-28 — *Kiawah Island, SC:* **Clinical Genetics.** AMA Category 1 and AAFP prescribed credit. Contact Div. of Cont. Ed., MCG, Augusta 30912. PH:404/828-3967.

AUGUST

2-5 — *Kiawah Island, SC:* **Critical Care Medicine.** AMA Category 1 and AAFP prescribed credit. Contact Div. of Cont. Ed., MCG, Augusta 30912. PH:404/828-3967.

6-10 — *Hilton Head Island, SC:* **Your Practice, Your Money, Your Family.** Category 1 credit. Contact Div. of Cont. Ed., MCG, Augusta 30912. PH:404/828-3967.

11 — *Atlanta:* **Experimental Hematology.** Category 1 credit. Contact Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., NE, Atlanta 30322. PH:404/329-5695.

12-16 — *Amelia Island, FL:* **Abdominal and Neuroimaging — Interventional Techniques.** Category 1 credit. Contact Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., NE, Atlanta 30322. PH:404/329-5695.

13 — *Atlanta:* **Comprehensive Board Review in Internal Medicine.** Category 1 credit. Contact Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., NE, Atlanta 30322. PH:404/329-5695.

14-16 — *Atlanta:* **Let's Talk Family Planning.** Category 1 credit. Contact Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., NE, Atlanta 30322. PH:404/329-5695.

17-19 — *Jekyll Island:* **Georgia Psychiatric Association Summer Meeting.** Category 1 credit. Contact J. Tom Sawyer, MAG, 938 Peachtree St., NE, Atlanta 30309. PH:404/876-7535 or 1-800-282-0224 (toll free in Ga.).

23-26 — *Hilton Head Island, SC:* **MAG Legislative Conference.** Category 1 credit. Contact Hollie Ross, MAG, 938 Peachtree St., NE, Atlanta 30309. PH:404/876-7535 or 1-800-282-0224 (toll free in Ga.).

SEPTEMBER

6-8 — *Atlanta:* **Southeastern Occupational Health Conference.** Contact T. R. Hatfield, MD, P.O. Box 71, West Point 31833. PH:404/756-7111 ext. 2204.

7-8 — *Atlanta:* **Office Urodynamics.** Contact Merrily Laube, Southern Found. for Edu. and Medical Research, Inc., 98 Currier St., Atlanta 30308. PH:404/688-3323.

12-14 — *Savannah:* **Neonatology — The Sick Newborn.** Category 1 credit. Contact Div. of Cont. Ed., MCG, Augusta 30912. PH:404/828-3967.

14-16 — *Hilton Head Island, SC:* **The Georgia Society of Anesthesiologists and the South Carolina Society of Anesthesiologists Fall Meeting.** Category 1 credit. Contact William Hammonds, Secy.-Treas., Ga. Society of Anesth., Emory Univ. Hosp., 1364 Clifton Rd., NE, Atlanta 30322. PH:404/321-0111.

20-23 — *Sea Island:* **Georgia Surgical Society Annual Meeting.** Category 1 credit. Contact William C. McGarity, MD, Emory Univ. Clinic, 1365 Clifton Rd., NE, Atlanta 30322. PH:404/321-0111 x 3322.

23-26 — *Sea Island:* **Georgia Urological Association Annual Meeting.** Contact Richard Estes, MD, Secy.-Treas., 35 Collier Rd., NW, Ste. 700, Atlanta 30308. PH:404/355-0813.

28-30 — *St. Simons Island:* **Georgia Gastroenterologic Society Annual Scientific Sessions.** Category 1 credit. Contact Theodore Hersh, MD, Emory University Clinic, 1365 Clifton Rd., NE, Atlanta 30322. PH:404/321-0111.

OCTOBER

4-6 — *Atlanta:* **Endourology.** Contact Merrily Laube, Southern Found. for Edu. and Medical Research, Inc., 98 Currier St., Atlanta 30308. PH:404/688-3323.

4-6 — *Hilton Head Island, SC:* **Frontiers in Nutrition** (cosponsored with Vanderbilt Univ. Sch. of Med.) AMA Category 1 and AAFP prescribed credit. Contact Div. of Cont. Ed., MCG, Augusta 30912. PH:404/828-3967.

18-21 — *Sea Island:* **Georgia Orthopaedic Society Annual Meeting.** Category 1 credit. Contact William Collins, MD, Secy.-Treas., GOS, 993 Johnson Ferry Rd., NE, Ste. 100, Atlanta 30342. PH:404/255-4582.

23-27 — *Atlanta:* **27th Annual Radiology Conference: NMR.** Category 1 credit. Contact Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., NE, Atlanta 30322. PH:404/329-5695.

NOVEMBER

4-7 — *New Orleans, LA:* **Southern Medical Association 78th Annual Scientific Assembly.** Contact Southern Med. Assn., 2601 Highland Ave., Birmingham, AL 35201.

5-10 — *Atlanta:* **American Society of Cytology.** Contact ASC, 130 S. 9th St., Ste. 810, Philadelphia, PA 19107. PH:215/922-3880.

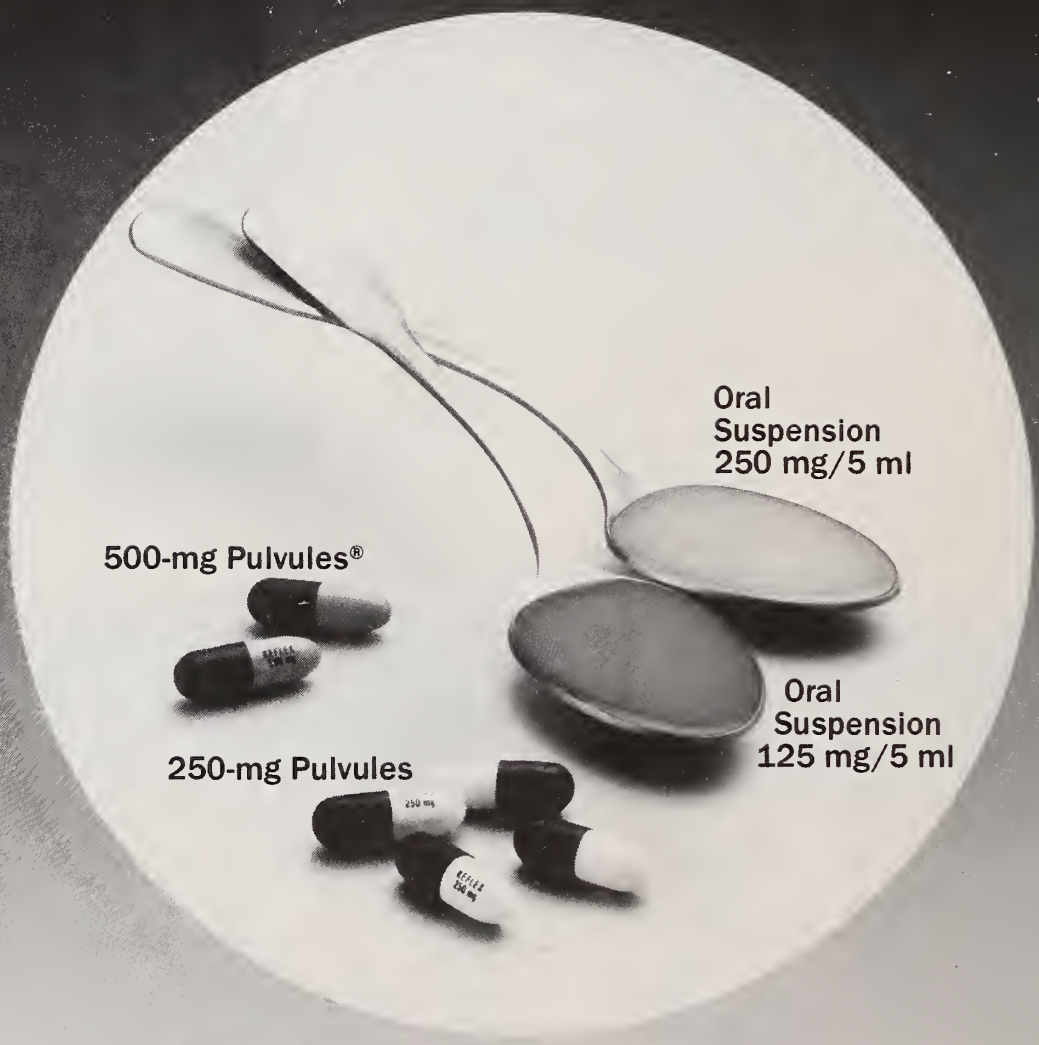
11-16 — *Atlanta:* **American Academy of Ophthalmology.** Contact AAO, P.O. Box 7424, 1833 Filmore St., San Francisco, CA 94120. PH:415/921-4700.

15-18 — *Atlanta:* **Georgia Academy of Family Physicians Annual Meeting.** Category 1 and AAFP prescribed credit. Contact Camille Day, Exec. Vice-Pres., GAFP, 11 Corporate Square, Ste. 205, Atlanta 30329. PH:404/321-7445.

16-18 — *Atlanta:* **MAG Scientific Assembly.** Category 1 credit. Contact Stephen Davis, Dir. of Ed., MAG, 938 Peachtree St., NE, Atlanta 30309. PH:404/876-7535 or 1-800-282-0224 (toll free in Ga.).

28-Dec. 2 — *Atlanta:* **Ninth Southeastern Conference on Alcohol and Drug Abuse.** Contact Barbara Turner, Charter Med. Corp., Addictive Disease Div., 5780 Peachtree-Dunwoody Rd., N.E., #170, Atlanta 30342.

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(BRIEF SUMMARY)

DESCRIPTION:
Each tablet contains 200 mg meprobamate and 325 mg aspirin.

INDICATIONS:
Adjunct in short-term treatment of pain accompanied by tension and/or anxiety in patients with musculoskeletal disease. Clinical trials demonstrated that in these situations relief of pain is somewhat greater than with aspirin alone. Effectiveness in long-term use, i.e. over 4 months, has not been assessed by systematic clinical studies. Physicians should periodically reassess usefulness of drug for individual patients.

CONTRAINDICATIONS:
ASPIRIN: Allergic or idiosyncratic reactions to aspirin or related compounds.

MEPROBAMATE: Acute intermittent porphyria; allergic or idiosyncratic reactions to meprobamate or related compounds, e.g. carisoprodol, mebutamate, or carbromal.

WARNINGS:
ASPIRIN: Use salicylates with extreme caution in patients with peptic ulcer, asthma, coagulation abnormalities, hypoprothrombinemia, vitamin K deficiency, or those on anticoagulants. In rare instances, aspirin in persons allergic to salicylates may result in life-threatening allergic episodes.

MEPROBAMATE: DRUG DEPENDENCE: Physical and psychological dependence, and abuse have occurred. Chronic intoxication from prolonged ingestion of, usually, greater than recommended doses is manifested by ataxia, slurred speech, and vertigo. Therefore, carefully supervise dose and amounts prescribed and avoid prolonged use, especially in alcoholics and others with known propensity for taking excessive quantities of drugs. Sudden withdrawal after prolonged and excessive use may precipitate recurrence of preexisting symptoms, e.g. anxiety, anorexia, or insomnia, or withdrawal reactions, e.g., vomiting, ataxia, tremors, muscle twitching, confusional states, hallucinosis, and, rarely, convulsive seizures. Such seizures are more likely in persons with CNS damage or preexistent or latent convulsive disorders. Onset of withdrawal symptoms occurs usually within 12 to 48 hours after discontinuation; symptoms usually cease within next 12- to 48-hour period. When excessive dosage has continued for weeks or months, reduce dosage gradually over 1 to 2 weeks rather than stop abruptly. Alternatively, a short-acting barbiturate may be substituted, then gradually withdrawn.

POTENTIALLY HAZARDOUS TASKS: Warn patients meprobamate may impair mental or physical abilities required for potentially hazardous tasks, e.g., driving or operating machinery.

ADDITIVE EFFECTS: Since CNS-suppressant effects of meprobamate and alcohol or meprobamate and other psychotropic drugs may be additive, exercise caution with patients taking more than one of these agents simultaneously.

USAGE IN PREGNANCY AND LACTATION:
An increased risk of congenital malformations associated with minor tranquilizers (meprobamate, chlordiazepoxide, and diazepam) during first trimester of pregnancy, has been suggested in several studies. Because use of these drugs is rarely a matter of urgency, their use during this period should almost always be avoided. The possibility that a woman of childbearing potential may be pregnant at time of institution of therapy should be considered. Advise patients if they become pregnant during therapy or intend to become pregnant to communicate with their physician about desirability of discontinuing the drug.

Meprobamate passes the placental barrier. It is present both in umbilical-cord blood at or near maternal plasma levels and in breast milk of lactating mothers at concentrations two to four times that of maternal plasma. When use of meprobamate is contemplated in breastfeeding patients, consider the drug's higher concentrations in breast milk as compared to maternal plasma levels.

USAGE IN CHILDREN: Keep preparations with aspirin out of reach of children. Equagesic® (meprobamate with aspirin) is not recommended for patients 12 years of age and under.

PRECAUTIONS:
ASPIRIN: Salicylates antagonize uricosuric activity of probenecid and sulfinpyrazone. Salicylates are reported to enhance hypoglycemic effect of sulfonylurea antidiabetics.

MEPROBAMATE: Use lowest effective dose, particularly in elderly and/or debilitated, to preclude over-sedation. Meprobamate is metabolized in the liver and excreted by the kidney; to avoid excess accumulation exercise caution in its use in patients with compromised liver or kidney function. Meprobamate occasionally may precipitate seizures in epileptic patients. It should be prescribed cautiously and in small quantities to patients with suicidal tendencies.

ADVERSE REACTIONS:
ASPIRIN: May cause epigastric discomfort, nausea, and vomiting. Hypersensitivity reactions, including urticaria, angioneurotic edema, purpura, asthma, and anaphylaxis may rarely occur. Patients receiving large doses of salicylates may develop tinnitus.

MEPROBAMATE: CNS: Drowsiness, ataxia, dizziness, slurred speech, headache, vertigo, weakness, paresthesias, impairment of visual accommodation, euphoria, overstimulation, paradoxical excitement, fast EEG activity.

GI: Nausea, vomiting, diarrhea.

CARDIOVASCULAR: Palpitation, tachycardia, various forms of arrhythmia, transient ECG changes, syncope, hypotensive crisis.

ALLERGIC OR IDIOSYNCRATIC: Milder reactions are characterized by itchy, urticarial, or erythematous maculopapular rash, generalized or confined to the groin. Other reactions include leukopenia, acute nonthrombocytopenic purpura, petechiae, ecchymoses, eosinophilia, peripheral edema, adenopathy, fever, fixed drug eruption with cross-reaction to carisoprodol, and cross-sensitivity between meprobamate/mebutamate and meprobamate/carbromal. Rare, more severe hypersensitivity reactions include hyperpyrexia, chills, angioneurotic edema, bronchospasm, oliguria, and anuria. Also, anaphylaxis, exfoliative dermatitis, stomatitis, and proctitis. Stevens-Johnson syndrome and bullous dermatitis have occurred.

HEMATOLOGIC (SEE ALSO "ALLERGIC OR IDIOSYNCRATIC"): Agranulocytosis, aplastic anemia have been reported, although no causal relationship has been established, and thrombocytopenic purpura.

OTHER: Exacerbation of porphyric symptoms.

DOSAGE AND ADMINISTRATION:
Usual dose is one or two tablets, 3 to 4 times daily as needed for relief of pain when tension or anxiety is present. Not recommended for patients 12 years of age and under.

OVERDOSAGE:
Treatment is essentially symptomatic and supportive. Any drug remaining in the stomach should be removed. Induction of vomiting or gastric lavage may be indicated. Activated charcoal may reduce absorption of both aspirin and meprobamate. Aspirin overdosage produces usual symptoms and signs of salicylate intoxication. Observation and treatment should include management of hyperthermia, specific parenteral electrolyte therapy for ketoacidosis and dehydration, watching for evidence of hemorrhagic manifestations due to hypoprothrombinemia which, if it occurs, usually requires whole-blood transfusions. Suicidal attempts with meprobamate have resulted in drowsiness, lethargy, stupor, ataxia, coma, shock, vasomotor and respiratory collapse. Some suicidal attempts have been fatal. The following data, reported in the literature and from other sources, are not expected to correlate with each case (considering factors such as individual susceptibility and length of time from ingestion to treatment), but represent usual ranges reported. Acute simple overdose (meprobamate alone). Death has been reported with ingestion of as little as 12 grams meprobamate and survival with as much as 40 grams.

BLOOD LEVELS:
0.5-2.0 mg percent represents usual blood-level range of meprobamate after therapeutic doses. The level may occasionally be as high as 3.0 mg percent.

3-10 mg percent usually corresponds to findings of mild-to-moderate symptoms of overdosage, such as stupor or light coma.

10-20 mg percent usually corresponds to deeper coma, requiring more intensive treatment. Some fatalities occur.

At levels greater than 20 mg percent, more fatalities than survivals can be expected.

Acute combined overdose (meprobamate with other psychotropic drugs or alcohol): Since effects can be additive, history of ingestion of a low dose of meprobamate plus any of these compounds (or of a relatively low blood or tissue level) cannot be used as a prognostic indicator.

In cases of excessive doses, sleep ensues rapidly and blood pressure, pulse, and respiratory rates are reduced to basal levels. Any drug remaining in stomach should be removed and symptomatic treatment given. Should respiration or blood pressure become compromised, respiratory assistance, CNS stimulants, and pressor agents should be administered cautiously as indicated. Diuresis, osmotic (mannitol) diuresis, peritoneal dialysis, and hemodialysis have been used successfully in removing both aspirin and meprobamate. Alkalinization of the urine increases excretion of salicylates. Careful monitoring of urinary output is necessary, and caution should be taken to avoid overhydration. Relapse and death, after initial recovery, have been attributed to incomplete gastric emptying and delayed absorption.

HOW SUPPLIED:
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Reproductive Effects of Aerobic Exercise in Women

JOE B. MASSEY, M.D., *Atlanta**

THE EVER INCREASING popularity of physical fitness in the United States has led to questions regarding possible special risks taken by women. The hypothalamic pituitary axis is sensitive to the effects of moderate to high levels of sustained aerobic physical exertion. The resultant episodes of anovulation with oligomenorrhea or amenorrhea can be considered to be protective in that they provide fertility control during times of physical stress.

Effects on Menstrual Cycles

Studies of primitive societies have suggested that adolescents' attainment and maintenance of cyclical reproductive function is dependent on a minimal weight for height.[1] Modern adolescents involved in intense activities such as ballet dancing and endurance sports are about 10-15% below normal in percentage of body fat. However, these girls also have a delay in puberty of 2 to 3 years which cannot be explained by low weight alone. There may be a fairly normal pubarche and a remarkable delay in thelarche due to normal testosterone levels but lack of estrogen. Endocrine studies of these teenage athletes have shown hypothalamic hypofunction and delayed bone age. The delay in menarche thus delays epiphyseal closure and increases limb length. This somatic change conforms to the particular aesthetic standards of the dancing community and may confer athletic advantage as well.[1]

Mental and emotional stress is an additional factor capable of inducing amenorrhea. Students in intensive music training programs with highly goal-oriented lifestyles have delays in menarche. However, dancers and athletes have much more significantly delayed menarche than musicians.[1]

Once menarche has been attained, the menstrual cycles continue to be quite sensitive in a number of individuals. Women who train intensively have a high incidence of secondary menstrual dysfunction which cannot be explained by weight change alone. Russell *et al*[2] at Grady Memorial Hospital measured endorphins and catechol estrogens in post menarchal girls training at the Dynamo Swim Club, a nationally ranked competitive club in DeKalb County. Higher blood levels of these hormones were found when comparing maximum intensity training state to maintenance levels of training without further weight loss. The higher training levels also were shown to correlate with the onset of oligomenorrhea. LH and estradiol secretion were suppressed. Similar effects were observed in adult runners as luteal phase inadequacy developed as higher levels of mileage were run.[3] Thus, from two endurance sports, it is apparent that levels of training affect the likelihood of suppressed cyclic menstrual function.

Some women do not become amenorrheic even with high levels of training. Among runners, the incidence of amenorrhea is 20% at a level of training of 20 miles per week, equivalent to the average 10 kilometer Peachtree Road Race participant. Quadrupling this training level to over 70 miles per week increases the likelihood of amenorrhea to only about 45% (Figure 1).[4] It is apparent that many women are reasonably resistant to stress amenorrhea induced by high intensity training. Another modifier is low body weight which does correlate with prevalence of amenorrhea.[5] Thus, the very asthenic woman who trains intensely is at highest risk.

* Dr. Massey practices obstetrics and gynecology and is a member of MAG's Medical Aspects of Sports Committee. This article is the first in a series sponsored by this committee. Send reprint requests to Dr. Massey at 993 Johnson Ferry Rd., Suite 240F, Atlanta, GA 30342.

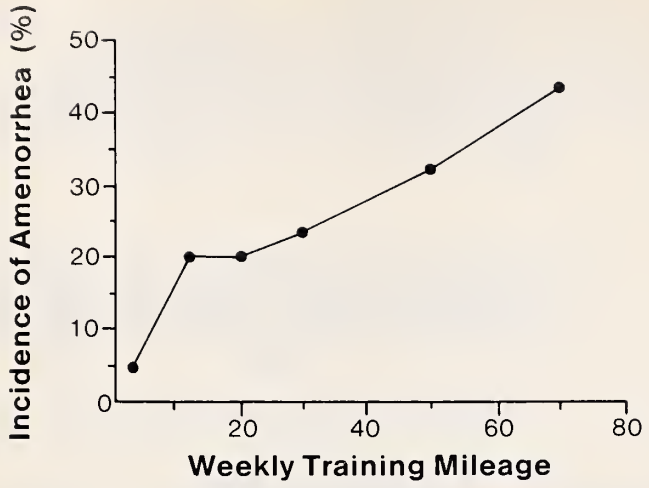


Figure 1 — The correlation between running mileage and amenorrhea.[4]

Physicians should not assume, however, that women in training programs are amenorrheic because of the stress involved in training. Women with prolonged amenorrhea should be investigated with a serum LH and FSH. The expected finding, if amenorrhea is due to training, would be that the LH and FSH would be in basal states, below 20 mIU/ml. High serum FSH would suggest ovarian failure. A fasting serum prolactin level would be used to rule out a tumor of the pituitary. In adolescents, physical examination and a bone age study will allow prediction of time of onset of menses and final height. Thyroid function testing would complete the laboratory workup in most cases. Abnormalities in these laboratory values should lead to further evaluation.

These amenorrheic women should have a 5-day course of medroxprogesterone acetate in order to ascertain the level of endometrial response to endogenous estrogen. Those women who do bleed in response to this progestin challenge should then be treated similarly three or four times a year in order to avoid endometrial hyperplasia. Those who do not respond are considered hypoestrogenic.

Shangold[6] feels very strongly that amenorrheic hypoestrogenic women athletes should have supplemental estrogen therapy to prevent osteoporosis. She cites early evidence that these women have marked bone loss not compensated by exercise. Such athletes have experienced stress fractures. A low dose birth control pill provides estrogen, contraceptive safety, and cyclic menstrual flow control. An alternative therapy would be conjugated equine estrogen, 0.625 mg per day or equivalent for 25 days, with added progestin for the last 10 days of the cycle, as in any estrogen replacement therapy. Other authorities have not been ready to recommend therapy based on the available evidence.

The effects of physical stress are generally reversible with cessation of the stress and with weight gain. However, 20-30% of patients will have persistent amenorrhea. Assuming the workup has not revealed pathology, then induction of ovulation would be appropriate if fertility is desired. Only at the time of desired reproduction should women be advised to reduce exertion and gain weight in order to ovulate. The benefits of aerobic conditioning certainly outweigh the risk of menstrual dysfunction for most women.

Effects in Pregnancy

Until recent years, the admonition to stop activities and assume a sedentary lifestyle during pregnancy was accepted. For women in good physical condition, the idea of almost a year without any training is unacceptable unless there is a definite risk. There are three potential areas of concern for pregnant women.

First of all, the possibility of risk to the mother herself must be considered due to the enormous cardiovascular effects of pregnancy with the increased blood volume, cardiac workload, and increased respiratory effort required by pregnancy. As far as this writer is able to determine by surveying reports of myocardial infarctions and sudden death in adult athletes, there have been no reports of pregnant women in either of these categories. Predictably, however, women with occult cardiac disease will suffer consequences of athletic exertion in pregnancy.

Among runners, the incidence of amenorrhea is 20% at a level of training of 20 miles per week, equivalent to the average 10 kilometer Peachtree Road Race participant.

The second concern regards that of the possibility of congenital defects in infants due to increased core temperature at the time of prolonged aerobic conditioning activities such as cycling, running, and swimming. Activities such as tennis are not in the risk category. It is known from animal studies that there is an increase of severe congenital anomalies associated with fever due to illness during organogenesis.[7] It is not known what the threshold for these effects may be, but there is suggestive evidence in humans of similar effects.[8] In the absence of data, it would seem prudent that in the first trimester women reduce the training to about half an hour or so of endurance activities. An alternative would be to monitor body temperature during or immediately after training and avoid rises of over two degrees Fahrenheit.

The third area of concern for pregnant women regards the safety of aerobic conditioning in the latter part of pregnancy.

Animal data show effects such as lowering of fetal pO_2 during physical exertion.[9] Transient fetal heart

rate decreases during exertion in women on treadmills have been noted by studies at Emory.[10] It appears that the normal fetus compensates well for these changes. Retrospective study of the outcome of pregnancies in women who exercised show that the outcome was at least as good if not better than controls.[11, 12] Part of this may be due to selection bias. For example, a lower prematurity or cesarean section rate in the exercising population than in controls could reflect beneficial effects of being physically fit. There may be other selection factors such as personality type, socioeconomic class, and selection of mode of anesthetic in the two populations which may not be comparable. Closely matched prospective observations need to be made in this field.

What, then, is a reasonable recommendation for exercising during pregnancy? Slowing down to a maximum of 30 minutes of aerobic activity per day, a level of exercise which avoids high core temperature in the first trimester, seems reasonable. Muscle toning exercises may be continued without concern; abdominal and back exercises are most important. Further decrease in aerobic activity in the third trimester is probably advisable and usually dictated by fatigue. Further restrictions would be advisable in pregnancies involving compromised fetal blood flow such as twins or maternal hypertension.

The admonition to refrain from normal physical activities until 6 weeks after delivery seems to be unnecessary. About 4½ weeks after delivery many women are able to make early steps toward gradually restoring their desired level of physical fitness.

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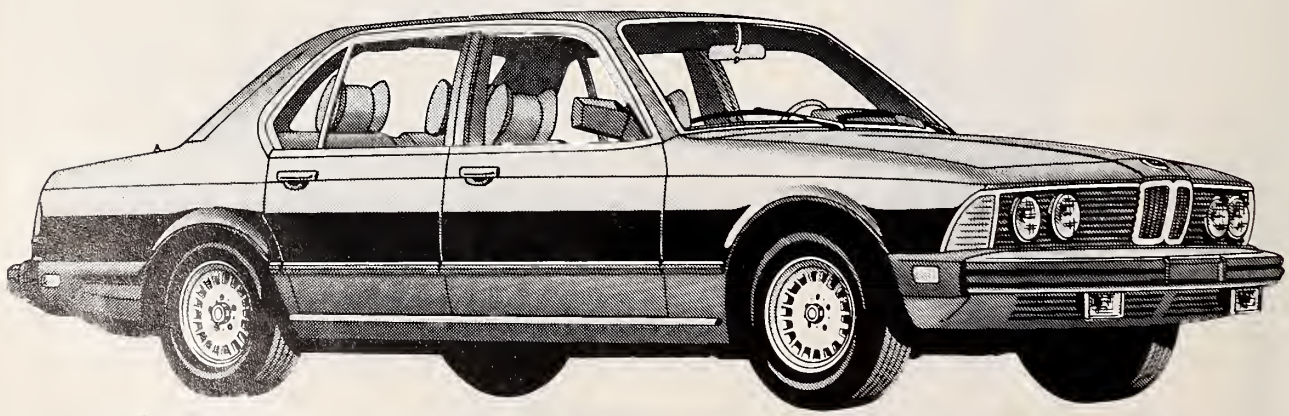
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The authors describe the public's awareness of the educational effort which led up to passage of Georgia's mandatory child seat law, and they review basic considerations and preventive strategies to protect children in automobiles.

Child Passenger Safety in Georgia

WILLIAM WESTON, III, M.D., *Augusta,* **and STUART LEVI, M.D.,** *Macon**

INJURIES INFLICT more disability and death on children in the United States than any other condition, representing a waste of potentially productive lives and placing a tremendous strain on limited health care resources. About half the childhood deaths caused by trauma involve the motor vehicle. During the years 1978-82, nearly 3,400 passengers under 5 years of age were killed in traffic accidents.[1] During the same period, an additional 250,000 infants and small children were injured. The average cost to care for such a patient in the hospital increased from $7,000 per accident in 1978 to $10,000 per accident in 1982. Survivors from this group have a high incidence of spinal cord injury, epilepsy, and mental retardation. Scherz's retrospective study in the state of Washington indicated that up to 90% of the fatalities and 67% of the disabling injuries over a 10-year period could have been prevented by the proper use of child safety seats.[2]

Legislation plus education appears to be the best combination for increased carseat usage. Therefore, in 1983, physicians, medical auxiliaries, legislators, government officials, and safety advocates campaigned successfully to pass a Georgia mandatory child seat law, effective July 1, 1984. This article describes the public's awareness of the educational effort which led up to passage of Georgia's law, and reviews basic considerations and preventive strategies which can protect our most valuable resource — America's children.

Basic Facts

Every motor vehicle accident involves two collisions.[3] The first involves the vehicle: it crashes into something. The second involves the occupants: they crash into the vehicle interior or are thrown from it. In the first collision, property damage can be replaced. In the second or human collision, a child's face or limb cannot be replaced.

In infants and small children, the head is large and heavy in relation to the body, resulting in a higher center of gravity. In a collision, they are likely to be catapulted head-first through the air toward the vehicle's point of impact, as a helpless "unguided missile" or human torpedo, producing a catastrophic result. Infants and toddlers also have less built-in anatomical protection against injury. Muscle mass, which provides some protection in adults, is less well developed. Not only is the skull thin and soft, but the spine is also less protected and more susceptible to injury. The rib cage of an infant or small child is flexible and offers less protection for the chest and upper abdominal organs. Finally, injured children do not show symptoms in the way that adults do, and their injuries are more difficult to diagnose and treat effectively.

Epidemiologic Considerations

Obviously, a health problem of this magnitude deserves vigorous scientific attention. Currently, the traditional emphasis on accidents as random events has been replaced by the approach to injury as preventable health problems. Indeed, the medical profession can view injuries in the same manner as we do disease processes. For example, a motor vehicle collision involves a host (child), an agent (automobile) and the environment (highways). Each component can be studied to determine which one had the primary influence on the injury occurrence. The analysis of injuries takes on greater significance if we add the hypothesis that events surrounding the injury are as important as the injury itself. Table 1 categorizes the sequence of events in a motor vehicle

* Dr. Weston is Professor of Pediatrics, Medical College of Georgia, Augusta, GA 30912; Dr. Levi is Associate Professor of Pediatrics, Mercer University School of Medicine, Macon. Send reprint requests to Dr. Weston.



1a



1b



1c



1d

Figure 1. — The on-lap crash. The on-lap crash is illustrated in this test conducted by the Insurance Institute for Highway Safety. A 1979 four-door Chevrolet Malibu is driven into a solid barrier at 24 mph. 1a: the pre-crash position of the unbelted mother holding her baby on her lap. 1b: One tenth of a second after impact mother and child are about to hit the dash and windshield. 1c: The mother's body crushes the infant only 3/20 second after impact. 1d: One half second into the crash, the damage is done.

collision — pre-crash, crash, and post-crash — and gives an example of a preventive intervention which has prevented or reduced injury.

Clinical Application

The crash phase determines whether an injury will occur once the incident has been initiated. Figure 1 depicts what happens to children sitting on the laps of adults in automobile crashes.[4] However, when secured in child safety seats, they can survive severe collisions with little or no injury. The seats work like safety belts, except that they are more effective for young children: (1) there is a "ride down" benefit, in which the belt begins to stop the wearer as the car is stopping; (2) they distribute the impact over time (by the belt's stretching); (3) they distribute the forces across the child's body; (4) they prevent the child from striking the more hostile forces of the car's interior, other passengers, or the pavement. The following case histories highlight the contrast in the outcome of an unprotected child versus a protected one:

20-Month-Old White Female — It was Christmas week, 1981. The roads were clear, but an oncoming car swerved in front of the car being driven by the patient's father. As a result of the collision, he had multiple jaw fractures and his wife had a fractured femur. Several days later, in Talmadge Hospital, the child's grandmother says, "The little dear was standing in the front seat. Her mother pushed her down, but her face was badly bruised and her stomach caught on the gear shift. Unfortunately the plastic knob had come off and her belly was ripped open." Treatment included intensive care and major surgery during a 10-day hospitalization.

9-Month-Old White Male — It was mid-January, 1982. The ice on the roads was starting to melt. K.G. of Alpharetta, Georgia, was driving her pick-up truck. Her son was with her, snugly strapped in his carseat. They had just started down a hill when they hit a patch of ice in the road. As Katie, the mother, recalls: "I applied the brakes, but could not stop. I turned the wheel towards the embankment, hoping the impact would stop us. Since the bed of the truck

TABLE 1 — Sequence of Events in Motor Vehicle Collision and Preventive Intervention

	Preventive Intervention
Pre-crash	Beginning in 1973, the 55-mph speed limit has resulted in saving an estimated 40,000 lives.
Crash	Tennessee, the first state to require child safety seats by law, reports a 65% reduction in fatalities from birth through four years.
Post-crash	A North Carolina community built and staffed its new hospital to accommodate trauma victims, improving the outcome for head injury victims.

had nothing in it, we became airborne after crashing into the embankment. We rolled over onto the roof and then over again back onto the tires. All I can say is thank God my baby was strapped in an the car seat was tethered. He didn't even cry.'' Treatment consisted of a reassuring office visit.

Program Approaches to Increased Usage

A wise man once said, ''A problem clearly seen is half-solved.'' Physicians for Automotive Safety, a volunteer organization based in the New York area, initiated the task of educating the public about child passenger protection. European and other foreign countries had taken the lead in this endeavor; for example, in the 1970s, West Germany mandated seat belts and would not allow children under 12 years to ride in the front seat of an automobile. Table 2 overviews the major efforts related to the evolution of child safety seats in the United States over the past two decades.[3]

In 1981, the Georgia Chapter of the American Academy of Pediatrics through its Committee on Accident Prevention established a child passenger safety program. Three major goals were identified: to teach a preventive carseat strategy in hospital prenatal classes, to increase public awareness of the problem through a network of physician spokespersons, and to promote passage of child safety seat legislation. These efforts were assisted by a 3-year public service award from the Governor's Office of Highway Safety through the Medical College of Georgia.

Education, 1981-1983

The Executive Secretary of the Georgia Chapter of the American Academy of Pediatrics, William Mankin, visited each of the 28 hospitals in Georgia that had more than 1000 births annually. During his visitation, he met with the obstetrics-pediatric nurse supervisor and provided her with a locally produced video cassette, ''Baby Safe,'' and a car safety seat demonstrator. A preliminary survey indicates that at least 14 of the 28 hospitals have continued to present this material in their prenatal classes, reaching more than 15,000 expectant parents each year. By December, 1983, twenty-five loaner programs had been established throughout the state. These child safety seat rental programs offer usage incentives by making systems available at low cost ($10) and by giving families an opportunity to try them before purchase. As an added incentive, many programs incorporate a ''buy back'' policy. The goal of these programs is to promote a cycle of responsible passenger behavior: infants and toddlers who adapt to riding in child safety systems readily adapt to using seat belts; children who use seat belts are more likely to continue this behavior as adults; and adults who use seat belts are more likely to place their infants in car safety seats.

Table 2 — Major Efforts Promoting Safety Seat Usage, United States

Year	*Activity*
1963	Pediatricians begin counseling parents on the need to protect their children in motor vehicles.
1966	Lap belts required in passenger vehicles
1978	Congress requires states to allocate 2% of highway safety funds to safety belt usage. Tennessee enacts mandatory law.
1980	American Academy of Pediatrics launches ''First Ride, A Safe Ride'' program (usually the trip home from the hospital).
1981	Federal Motor Vehicle Safety Standard 213 upgraded to require dynamic testing of safety seats manufactured.
1984	Forty-six states and the District of Columbia have passed mandatory child safety seat laws.

The network of 20 physicians was provided copies of the film, ''Children and Infants in Car Crashes'' to spread the word among colleagues and patients. Each participating doctor contacted area hospitals and district health officers about the need to introduce car safety seats. In addition, the physicians were encouraged to write letters to the editors of their local newspapers at an appropriate time in support of the educational and legislative plans. A newsletter, ''The Buckler,'' keeps participants informed about state and national issues.

Georgia's Law

The first attempt to pass legislation in the 1982 session failed in the House. After consultation with the Medical Association of Georgia's Lobby, the bill was reintroduced in 1983 in the Senate with the sponsorship of the majority leader, Senator Thomas Allgood. The statute came out of the Senate Transportation Committee with a ''do pass'' recommendation. The bill was referred to the House Motor Vehicle Committee and immediately encountered problems. Initially, the committee chairman was opposed because he felt it could impinge upon indi-

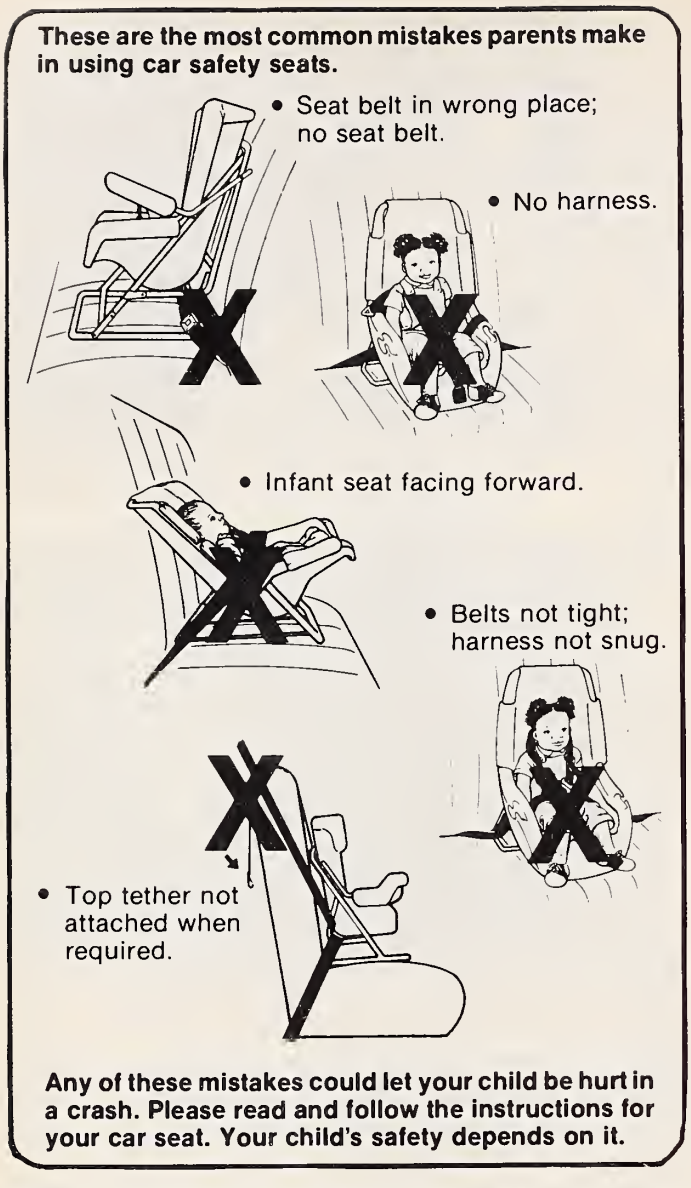


Figure 2 — Office poster depicting Misuse of Safety Seats. ***Courtesy:*** **"Safe Passage," Questor Juvenile Furniture Company, Piqua, Ohio 45356.**

Table 3 — 1982 Child Safety Seat Usage for Children Less Than Four Years of Age Killed or Injured in Traffic Accidents, Georgia

	Frequency of Restraint Usage (Percent)			
Age	Yes	No	Unknown	Total
0	483 (4.55)	586 (43.13)	1,120 (52.32)	
1	85 (17.07)	287 (57.63)	126 (25.30)	498
2	29 (8.08)	227 (63.23)	103 28.69	359
3	17 4.89	221 63.51	110 31.61	348
TOTALS	182 7.83	1,218 52.39	925 39.79	2,325

vidual rights and because enforcement would be difficult, if not impossible. With considerable help from physicians throughout the state, notably Martin Smith (Gainesville), Oscar Spivey (Macon), Lanier Nicholson (Hiawassee), Nelson Carswell (Dublin) and Scott James, David Morgan, and Booker Poe (Atlanta), legislators on the committee were contacted and convinced of the value of the law. The bill passed out of the committee with minor changes, and near the end of the Session was approved by the House with several amendments. The Medical Association of Georgia Lobby, notably Gould Hagler, provided superb support.

The statute (SB 59) was signed into law by Governor Joe Frank Harris in April, 1983, and reads:

> *Effective July 1, 1984: Every driver transporting children 0-4 years of age must provide for protection of such child in a child passenger restraining system approved by the United States Department of Transportation under Federal Motor Vehicle Safety Standard 213 in effect on January 1, 1983. Lap belts are sufficient for children between 3 and 4 years of age. Any person who violates this code shall be guilty of misdemeanor, punishable by a fine of not more than $25. Fine waived upon proof of purchase or rental within 14 days. Exemptions include non-residents, drivers of vehicle for hire, driver of car pool carrying children to church or school or when a child's personal needs are being attended to. Section 1c designated the Governor's Office of Highway Safety in cooperation with other agencies to implement, coordinate, and carry out a program which would inform Georgia citizens of the reasons for it.*

Education and Law, 1984

Table 3 gives an indication of child safety seat usage in Georgia during 1982.[5]

This indicates that 2,325 children under 4 years were killed or seriously injured during 1982. Less than 8% were using car safety seats. Approximately 43% more children were injured and killed when not restrained than when they were restrained.

Presently, a statewide task force is being organized to develop educational and marketing strategies for increasing child restraint usage. Components of a plan developed by the task force will include mass media, educational materials, and program incentives.[6]

The mass media phase will be initiated by a billboard campaign, jointly sponsored by the Medical Association of Georgia and the Georgia Sheriff's Association in cooperation with Turner Outdoor Advertising. "Car Seats Reduce Child Death 90%/ It's The Law — Effective 7/1/84." This message, with a graphic of an infant in a car safety seat, is planned for June, 1984. Simultaneously, local tele-

vision stations can present a public service announcement which will appeal to the majority of Georgians; a sports or television personality will also be promoting car safety seats.

Educational programs will be coordinated through the Governor's Office of Highway Safety. Law enforcement officers represent the key target group. They and other interested persons may get information about the law or safety seats by telephoning (404) 393-7480.

Insurance companies and pharmaceutical firms have provided incentives for establishing loaner programs by donating car safety seats in Macon, Augusta, and Atlanta. One merchandizing conglomerate has offered seats at a special price at an educational seminar, where, after viewing an instructional video cassette, area highway patrolmen conducted a question-answer session.

Provisions need to be made to assure that rural and minority populations have access to restraint systems. A mass distribution can be accomplished through a mall sale, where carseat manufacturers combine with merchants and safety advocates to make a truckload of seats available at a discount price. This type activity is being considered by the Georgia Chapter, American Academy of Pediatrics, in collaboration with several volunteer groups.

Physician Intervention

Crash-phase preventive strategies provide the busy practitioner the greatest opportunity to benefit his/her young patients. Physicians must choose educational techniques that are in keeping with the style and pace of their practice. Several principles must be kept in mind:

1. Personal Commitment — The physician must be convinced of the value of carseats and seatbelts. This means consistent use of safety restraints by physicians and their families. The success of parent and community education depends on our believing that what we are saying is important.
2. Perinatal Practices — Tell parents that the greatest need for baby's protection occurs during the first year of life. Insist that any baby you attend leave the hospital in a properly installed carseat, facing the rear of the automobile. Whenever indicated, write a prescription for the parents of an infant to obtain a carseat.
3. Office Environs — Display posters, pamphlets, and carseats. Make sure office staff are informed and involved. Have them offer to check parking lots to identify and to correct common mistakes parents make in using car safety seats. (Figure 2). Consider a reward when one is correctly installed and the baby properly secured. Tell parents that consistent use of carseats and seatbelts will improve children's behavior in automobile.

Conclusion

Our sister states, North Carolina and Tennessee, reported a threefold increase in carseat usage during the year of enactment. Georgia can improve on these figures. Physicians have taken the lead in child passenger safety. It is our responsibility and our unique privilege to participate in this attack on the "highway epidemic." How rewarding it will be to see the number of deaths from motor vehicle collisions under age 4 years fall from 22 annually to as few as two per year!

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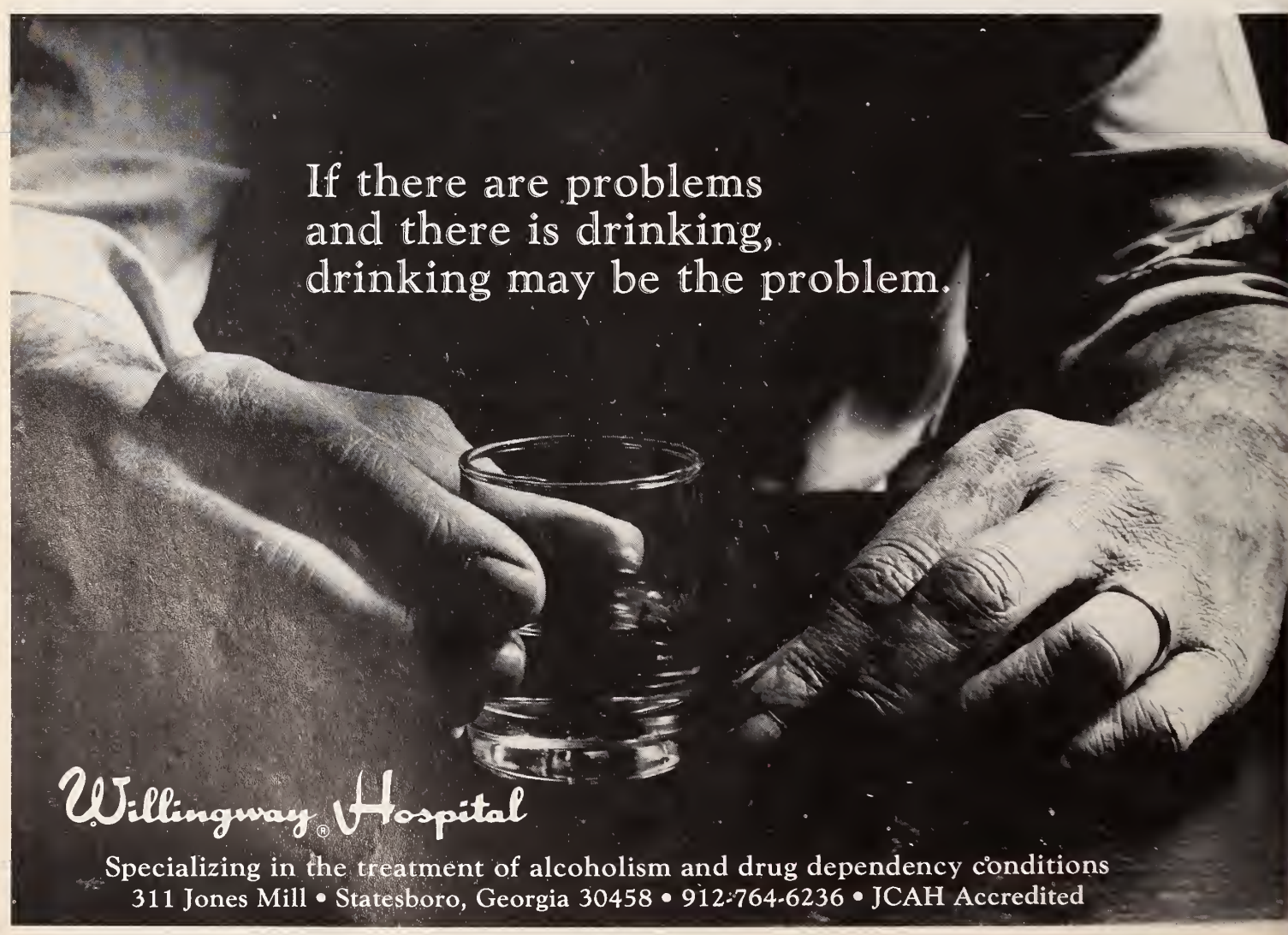
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The dramatic changes that have occurred in medical training and practice in the South in the last 25 years are described.

The Southern Regional Picture of Physician Manpower

HAROLD L. McPHEETERS, M.D., *Atlanta**

THE SOUTH HISTORICALLY has been a poor section of the nation. Traditionally, the South has had fewer physicians per 100,000 population and fewer medical schools than most other parts of the U.S. In addition, the South offered fewer opportunities for its medical graduates to enter residency training in a specialty. Many of the region's young physicians left the South to enter specialty training in other parts of the nation and then never returned to the South to practice. Thus, the region which was already short on physicians and young medical graduates was exporting a high proportion of those graduates. The situation was comparable to the "brain drain" experienced by many foreign nations that formerly sent young doctors to the U.S. for specialty training only to find that large numbers never returned to their native countries.

However, the past 20 years have seen a dramatic change in the physician manpower situation in the region. Since 1960, the 14 states of the South have opened 15 new medical schools, including a few that are so new that they have not yet reached their intended peak enrollments (e.g., Morehouse School of Medicine and Mercer School of Medicine). In addition, existing medical schools have increased their enrollments in response to federal capitation grants and state urgings. The result is that first-year enrollments in Southern medical schools have increased from 2,350 per year in 1960 to slightly over 5,000. It is estimated that from 1985 on, graduates will number 4,725 if no changes are made. The region will be producing as many physicians every 10 years as it did every 25 years before 1960. The 84 percent increase in medical graduates in the South between 1970 and 1979 was the highest for any region of the nation. Between 1980 and 2000, the South will nearly double the number of new physicians it has trained.

During these same 23 years, the South has increased the numbers of residency training programs so that there are now sufficient residency slots for all of the region's medical graduates. Of course, there are some Southern graduates who choose to take their postgraduate training in the North or West just as there are some graduates of those regions who choose to take their training in the South. On balance, however, the South is no longer losing its graduates to other parts of the nation because of a shortage of residency training opportunities.

First-year enrollments in Southern medical schools have increased from 2,350 per year in 1960 to slightly over 5,000 annually.

The South has also imported a large number of foreign-trained physicians who remain in practice here. During one 8-year period in the 1970s, the number of foreign trained physicians who located in the South increased by 87 percent, compared to only 31 percent in the rest of the nation. The large influx of foreign national physicians has been drastically slowed, but the numbers of foreign-trained American graduates has increased. It is still too early to know where these foreign graduates will locate. Most of them originate from New York, New Jersey, and California, but it is likely that many of them will choose to locate in the South.

* Dr. McPheeters is Director, Commission on Mental Health and Human Services, Southern Regional Education Board, 1340 Spring St., NW, Atlanta, GA 30309. Send reprint requests to him. This paper was presented at MAG's Leadership Conference Saturday afternoon program, "Training Future Physicians for the Competitive Medical Marketplace," in January, 1984.

Perhaps the most remarkable change in the physician manpower picture for the South is the in-migration of physicians from other parts of the nation. The growth reputation of the "Sunbelt South" is attracting physicians in numbers disproportionate to the overall migration to the South. In a 4-year period in the mid 1970s, a total of 2,033 physicians came to the South from other parts of the country, while only 318 left the region — a net gain of 1,715. At that rate, the increase in physicians from other parts of the nation is equal to the graduates of four medium sized medical schools. This trend has been accelerating according to the licensure boards in several states.

The overall result is that the physician/population ratio is increasing more rapidly than in other parts of the nation. In 1970, the South had 115 non-federal physicians per 100,000 population compared to a national average of 148 physicians per 100,000 population. By 1980, the national average had risen to 195 per 100,000, with 162 per 100,000 in the South — both well above the 150 per 100,000 population figure that both the World Health Organization and the Canadian government have defined as the level of adequacy.

The pressures for cost containment are likely to increase as coalitions of business and industry leaders seek ways to reduce the costs of their health care benefits.

Of course, the population of the South is also increasing but not nearly as rapidly as the growth in the number of physicians. The region still has problems in the poor distribution of physicians, although there are some improvements. Mississippi's 115 physicians per 100,000 population is less than half of Maryland's 286 per 100,000 and just a little over half of Florida's 212 per 100,000. As another example, half of Georgia's physicians are located in the standard metropolitan area of Atlanta. The region is still short in certain specialties, such as family practitioners and psychiatrists, and the region is far short of black physicians. Only 2.5 percent of the region's physicians are black in the region where 19 percent of the population is black. These imbalances are expected to persist even in the face of increases in the overall numbers of physicians unless some specific actions are implemented to change them.

Meanwhile, there are some other trends underway that are likely to affect the need for physicians and the ways in which they practice. One of these is the increasing corporization of the health care provider system. The development of private corporations or

Non-Federal Physician/100,000 Population Ratio National and States of the South 1963-1981

4	1963	1970	1975	1980	1981
National	135	148	169	195	200
South (14 states)	101	115	139	162	166
Alabama	79	90	103	130	134
Arkansas	89	92	103	128	134
Florida	132	155	185	208	212
Georgia	99	108	126	149	152
Kentucky	74	102	122	139	146
Louisiana	115	120	131	161	165
Maryland	153	183	217	281	286
Mississippi	78	84	94	112	115
North Carolina	100	111	132	162	165
South Carolina	80	93	114	143	146
Tennessee	110	119	139	163	168
Texas	105	117	135	159	162
Virginia	109	125	149	186	190
West Virginia	95	104	124	141	147

Source: Physician Characteristics and Distribution in the U.S., 1982 Edition, American Medical Association, Chicago, IL.

coalitions of providers includes nursing homes, general hospitals, psychiatric hospitals, and free-standing emergency clinics. This movement has progressed faster and further in the South and West than in other parts of the nation. Under the increasing pressures for cost containment of health care costs, these private entities are likely to be in a position to direct how physicians practice in their institutions. In general, the region has lagged in the development of Health Maintenance Organizations and Preferred Provider Organizations, but there is now a considerable rustle of activity in this area, especially in some of the cities.

The increasing competition is leading to the distribution of secondary care specialists and others to practice in smaller cities than had been the pattern in the early 1970s. The rigors of competition, however, are also leading more young physicians to choose salaried positions where they can practice medicine while having the security of an income that is becoming more difficult to assure through traditional independent practice.

The pressures for cost containment are likely to increase as coalitions of business and industry leaders seek ways to reduce the costs of their health care benefits. These, coupled with the pressures to reduce the cost of Medicare and Medicaid, are likely to aggravate the competitive pressures created by the increasing numbers of physicians being produced in and migrating to the South. The medical profession, the medical schools, and the region's policymakers need to be aware of these trends in order to make appropriate decisions about how to proceed.

How Georgia is facing the issues of medical education costs and physician supply and distribution is the main focus of this paper.

Medical Education in Georgia

HARRY B. O'REAR, M.D., *Augusta**

Health-Related Issues

THERE ARE, at any given time, one or two major health-related issues that are the focus of public attention and debate. (Usually there are two — one in the practice of medicine and one in the medical educational process.) These issues have cycles of about 10 years from the time they become the focus of attention until they are displaced by other issues.

Some of the health-related issues over the past several decades have included:

—Conquering of a disease or a group of diseases through infusion of great amounts of money into research and treatment.
—Need for more physicians (or some other health professional).
—Oversupply of physicians resulting in decreased enrollments and reduced specialists training.
—Medical school curriculum changes.
—More funds to provide more medical and health care for all the people, particularly those "disadvantaged."
—More involvement of medical schools with the community in solving social problems.
—Expensive medical care costs to be reduced by cutting back on payment to hospitals, clinics, and physicians.
—And so it goes.

Two Issues and Georgia's Response

The topics I will address are how the state is facing the issues of medical education costs and physician supply.

I am tempted to say that the state is facing the issue by expending more on medical education and increasing the supply by support to two new medical schools. But that would not give a very balanced view of a process that began in the early 1950s.

The cost of medical education can be addressed from several viewpoints — cost to the state, cost to the student and the student's family, or the cost to the state for the education of related health professionals.

In the 1950s, Georgia's cost of medical education (and that of the essential related health professionals) began to rise. This was the result of increasing enrollment in the entering class in medicine at the Medical College of Georgia (MCG) to 100, construction of a teaching hospital, and moving of the only state supported program in nursing to the Medical College.

In the 1960s, a number of new nursing programs were begun; a new type of nursing program, the associate degree, was begun; a state-supported dental school was authorized and students admitted; numerous allied health programs were initiated; two new schools of allied health sciences were begun; and research programs related to health began to flourish at three of the university level institutions.

The growth of publicly supported health professions programs continued into the 1970s, reaching a peak enrollment of approximately 7,600 students in 1976. They were enrolled in 32 different types of programs located in 28 of the 32 colleges and universities in the University System of Georgia.

Then, for several reasons, including the decline of federal support, enrollment dropped to about 7,000. It has remained at about that level. It should be

* Dr. O'Rear is Vice Chancellor for Health Affairs, University System of Georgia Board of Regents. This paper was presented at MAG's Leadership Conference Saturday afternoon program, "Training Future Physicians for the Competitive Medical Marketplace," in January, 1984. Send reprint requests to Dr. O'Rear at the Medical College of Georgia, School of Dentistry, Room AD 110, Augusta, GA 30912.

noted, however, that there have been shifts in enrollment fields. For example, the enrollment at MCG has increased. The entering class has risen, incrementally, to its present level of 180.

In the 1980s, the only planned change has been a decrease in the size of the entering class in dentistry at MCG. There have been some small declines in the number of students enrolled in some of the allied health programs.

Increase in the number of programs and the enrollment of such a magnitude have increased the cost of health professions education manyfold. The increase, however, has paralleled that of the other 13 states in the Southern Regional Education Board states, as Dr. McPheeters indicates (see p. 467). State support has increased significantly as federal support has declined.

The student's cost has also inceased significantly. It may continue to rise modestly as the University System is committed to raising fees to the point that students pay approximately 25% of the cost. In reality, though, this will not apply to medical, dental, and veterinary students. At the present time, medical and dental students at the Medical College of Georgia pay $2,240 per year or $747 per quarter in fees (activity, health, and other fees are not included). Fees for other students in other programs at other colleges or universities vary from $190 to $360 per quarter.

While costs for students have increased, the University System and the institutions have made every effort to increase scholarship and loan funds available. At the Medical College, the Financial Aid Office reported that in the past academic year, 1,400 students received $7,000,000 from scholarships, loans, work-study, and other programs. These figures include only those funds handled through the Financial Aid Office.

Steps Taken to Affect Distribution

The state, the University System, and the Medical College of Georgia have taken a number of steps and measures to affect the distribution of graduates in medicine.

Before examining these measures, it might be well to take a look at the counties from which medical students come and the counties in which they practice.

At the present time, students in medicine come from over 120 of Georgia's counties. The medical graduates practice in some 140 of the counties. That is a rather impressive distribution of the graduates when consideration is given the populations of the remaining counties. Three have populations of less than 3,000, and most of the remainder fall into the group having approximately 5,000. Furthermore, over 60% of the medical graduates practice within the state, and that is a very respectable percentage.

As to the efforts being made:

First and second-year students in the School of Medicine participate with community physicians in providing a continuum of care to one or more families.

Preceptorships are offered through one of the programs of the Joint Board of Family practice to over 100 students at MCG. The preceptorships are very popular. At the moment, they are oversubscribed.

A Family Medicine clerkship is a required part of the curriculum of the School of Medicine.

Outreach programs to communities with a lack of physicians are operated by the School of Medicine Department of Family Medicine. An outreach program of the department serves three of the five counties that have less than 5,000 population. Medical students have electives available that can add to their experience with small communities' needs in health care.

The Medical Education Board, which dates back to the 1950s, was funded to provide financial aid to students if the student agreed to serve in a community of 15,000 or less. The Board, established by the "Country Doctor Bill," awards between 30 and 35 scholarships each year. There are 133 students in medical school at the present time receiving such scholarships. In recent years, to prevent too many of the recipients from buying out of their obligation, the Medical Education Board has made it more difficult for the graduates to pay back their scholarship money. Applicants are screened more carefully and counseling is provided for the students who have received the awards.

In addition to funding the medical and health professions education within the University System, the state has entered into contracts with the Southern Regional Education Board (SREB) and other agencies to provide educational support on a capitation basis for students in private medical schools both within and outside the state. Support is also being given for osteopathic medical students.

For the next academic year, the state will contract through SREB for capitation fund support for 363 medical and osteopathic students. They are divided as follows:

Emory University	138 students
Morehouse College	80 students
Mercer University	88 students
West Virginia School of Osteopathic Medicine	28 students
Meharry Medical College	17 students
Other osteopathic schools	12 students

Fifty-one of the 363 students will be additions to the group.

The peak enrollment of medical and osteopathic students will not be reached until 1987. The nation as a whole peaked in 1981.

First-Year Postgraduate Positions

One note before continuing. Most of these comments and observations have concerned medical student education. Not to be forgotten in the overall picture is the availability and quality of first-year postgraduate positions — once known as internships. There are not enough first-year positions to accommodate the present number of graduates in the so called "primary care specialties." Only about 60% have been accommodated at the present time, and as noted, the peak years for medical graduates has not been reached. Also, the total number of residency positions for Family Practice is quite small. While the Family Practice residencies are increasing, Georgia lags behind other states in this area.

Special note should be taken of the efforts by the Joint Board of Family Practice to increase the number of Family Practice programs and residency positions. Currently, funds from the Joint Board are helping fund residency programs in Rome, Columbus, Atlanta, Savannah, and Macon. The Medical College supports the Family Practice program in Augusta.

Conclusion

Georgia has responded, as have the other states in the Southeast, to increase significantly the programs for the education and training of medical and related health professionals.

Private initiative has brought into being two new medical schools that have yet to graduate a fourth year class. These schools are receiving substantial state support, both capitation and general.

Peak enrollment for Georgia-supported programs will not be reached until 1987. In the next academic year, the state will be supporting through capitation funds 363 medical and osteopathic medicine students in private schools or schools outside the state. These are in addition to the 720 students at the Medical College of Georgia.

The number of first-year postgraduate positions available in the primary care specialties is currently about 60% of the number of graduates from Emory and MCG. With graduates from two more schools coming along, there is need for more first-year postgraduate positions. This is important because many studies have shown that physicians tend to practice in the state where they serve their residencies.

Finally, given the continued growth of medical education programs, which will not peak until 1987, there is no consensus that there is or will be an abundance or overabundance of physicians in the state.

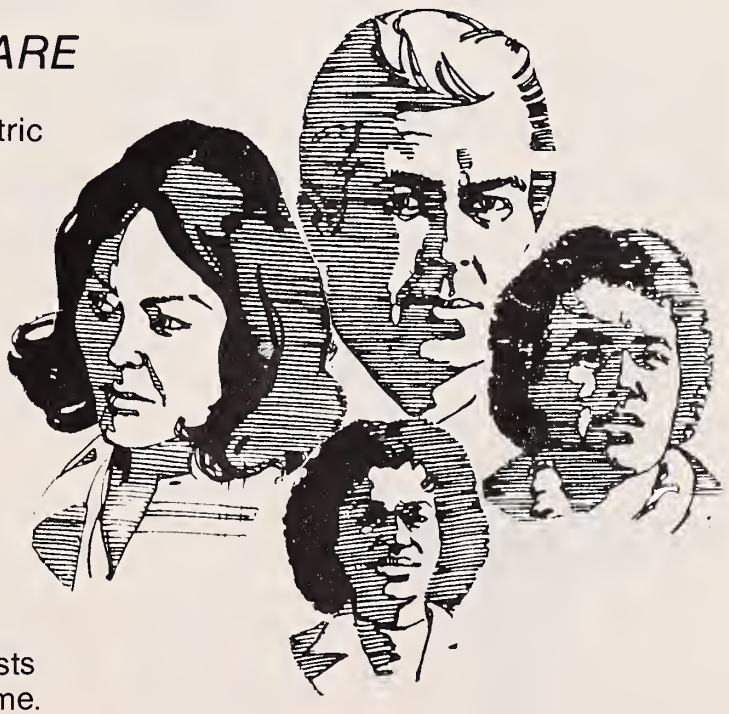
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The author discusses the psychologic ramifications of such painful, though predictable, family separations.

Military Family Separation — Togetherness Apart

ELI BREGER, M.D., *Savannah**

Introduction and Overview

MILITARY FAMILY SEPARATIONS are both the necessary and inevitable result of our government's maintenance of combat ready forces. Unaccompanied tours of duty will continue separating, in the traditional military family, the father from his wife and children. But what are the ramifications of such painful, though predictable, separations? According to an old saying, "the sailor sails and the family wails." Bereavement, anger, boredom, and mistrust are but a few of the emotions sparked by the interruption of "normal" family life.[1]

Though the concern for families undergoing the trials of military separations is not new, there is an increasing interest in military life in general. Here are some revealing statistics:

1) Between 1952 and 1972, the percentage of married military personnel increased from 30 to 59 percent (that number is probably even greater now);

2) Fifteen to 20 percent of all families in the military at any one time have a father who is away on deployment;

3) During a 20-year military career, there will be, on the average, four unaccompanied military tours, plus many shorter separations.[2]

Absence of the father, however, is not unique to the military. The fatherless family is a phenomenon whose incidence is noticeably increasing throughout our society. What is unique to the military is that the father is absent more frequently and for longer periods of time. In some instances, his tour of duty also involves considerable danger. On the positive side, these absences are expected and can be planned for; they are socially accepted experiences shared by other military families.

Separations affect what is known as the "family system," that is, the individual family members, each with an established role, tied together by complex dependencies, interdependencies, and balances. A healthy, flexible system is often able to withstand the stress of repeated separations, but complex variables within the system also have their effects. The effect of a separation upon a child, for example, is relative to that child's stage of development.[3]

Generally speaking, however, a family's reaction to separation is that of a crisis, a loss, containing elements similar to those of bereavement. The signs and symptoms are predictable. The first separation of great length is the most important. Most problems occur then and, if unresolved through subsequent separations, can gradually fragment a vulnerable family.[4] In any case, separations are always stressful if caring individuals are involved. Separations are never desirable; yet like other forms of stress, they can lead, with adaptation, to growth and strength.

Although this discussion will focus on the traditional configuration of the absent active-duty father, non-traditional families are also affected by military separations.[5] For example, an active-duty mother and an active-duty father may be stationed apart, one on deployment. One may also see a family consisting of an active-duty mother and a civilian father. Here it is the mother who is separated from the family, though this situation occurs in less than one percent of all separations. Solutions to child care in these special situations vary and may involve the extended family.

* Dr. Breger is Director, Child and Adolescent Services, Charter Broad Oaks Hospital, 5002 Waters Ave., Savannah, GA 31405. Send reprint requests to him.

Military family separations are as varied as the families involved, but in order to better manage the stress produced in any one case, an understanding of the following four points is necessary: 1) the impact of separation on individual family members, 2) coping skills, 3) characteristics of vulnerable families, and 4) the ultimate re-integration of the father into the family system. Once these points have been explored, specific suggestions for family adaptations can be made.

Impact of Separation on the Family System

Separations initiate a roller coaster pattern of adjustment which is felt at times by all members of the family. As a separation is anticipated, individual family members may show signs of withdrawal or anger directed at both the father and the military. After separation, the initial reaction is bereavement, that is, grief, sadness, mourning, accompanied by anxiety and insomnia. Anger may continue to be felt; guilt, too, may plague various members of the family. Gradually, however, if the family is healthy and adaptable, there is recovery.[6] A weak family may tend to disorganize, and it is by studying such families that one may learn much about successful coping skills.

Under the pressure of separation, for example, a wife may become dysfunctional. Her responsibilities decrease, and she withdraws from her usual social activities. At times she may be driven to flights of extreme sociability and illicit sexuality. Stress may lead to psychosomatic illness. Boredom, depression, and substance abuse are also common.[7]

Generally speaking, a family's reaction to military separation is that of a crisis, a loss, containing elements similar to those of bereavement.

Another case involves the dysfunctional husband, that is, the active-duty member himself. He, too, experiences bereavement, chronic worry, and a lack of confidence that his family can manage without him. He no longer feels in control of a situation in which he has been deprived of his role as father and leader. He may experience alienation, isolation, or distortions of reality concerning his family. Like the dysfunctional wife, he may attempt to lose himself in extra-marital relationships.[8]

Children, too, may become dysfunctional upon separation from their father. The father offers a model for sexual identification, takes part in rough and tumble play, and assists in the mastery of skills. He, thereby, helps the child toward the natural gradual separation from its mother. Children are particularly vulnerable during stages of developmental flux, during the normal push towards separation and individuation. An early period of separation and individuation occurs between the ages 2 and 4, though maternal loss at this time has a greater effect on children of either sex. Another period of vulnerability occurs between the ages of 4 and 6 years which corresponds to what psychoanalysts refer to as the oedipal period of development. This period is again characterized by separation and individuation, but complex psycho-sexual development also occurs. Children between the ages of 2 and 6, therefore, deeply feel the loss of their father. Such children tend to see separation as abandonment and view it with egocentricity. They are interested in how actions affect *them*. During their later school years and particularly in adolescence, children deal with separation more easily.

When children do become dysfunctional because of separation, they often exhibit fearfulness, anger, hostility and aggression, dependency and regression, in addition to diminished peer relationships. Although children often do best when their mothers adjust to separation, a child who is particularly vulnerable and disturbed may still have problems in spite of his mother's adjustment.[3]

Coping Skills

What constitutes a successful adaptation to separation? A family system capable of change, capable of reorganizing as a one-parent family, can adjust. In such a system, the mother who possesses "sex role adaptability" does best; she is able to be both father and mother to her child. In her mother role, she continues to demonstrate expressive behavior such as nurturence and support; in the father role, she adopts instrumental behavior such as training and discipline. After separation, sex role adaptability tends to correct certain imbalances, generating new strength, growth, and survival. The adoption of this dual role does not represent a total change in the wife, for all mothers and fathers have male and female elements within them. It is rather an enlargement. While sometimes confusing for children who witness a change in their mother's behavior, this adaptability proves to be an invaluable skill, especially for the military wife who must face repeated separations.[9]

A family willing to try something new — with a determination to make things work — also tends to do well, regardless of sex role adaptability. Its members recognize the "matriarchal family" as a valid unit. They know that a family can be complete when the father is absent.[10] In this case, the matriarchal "military wife" is the ideal model for this mode of adaptation. Characterized as a woman who shares her husband's occupation, she and her husband are two persons with one career. She is career enhancing

to her husband and is able to settle for limited autonomy and self development. She also tends to be supportive of the military, for she genuinely feels that the military life is good for her family. She can handle separations and function independently. Sex role adaptability — her ability to be a mother and a father — is probably involved in her success, but the great security which she finds in military life tends to be the overriding factor. She continues this role, year after year, weathering all separations, as the family moves from one military post to another.

Women who isolate themselves and do not avail themselves of available support systems fare poorly during their husbands' absences.

Other women, too, are able to cope with military separations. Some examples are as follows:

1) the woman who uses separation to develop autonomy — she may get a new job, go back to school, develop new activities, or participate in volunteer projects; she busies herself constructively;

2) one who is aware of her own feelings — if help is needed, she will probably seek support and counseling;

3) the woman who is able to express her feelings, to reach out, to talk of her feelings;

4) the one who is able to reach out for support from friends, community, extended family, and the military command — she is not isolated, but is aware instead of available support systems;

5) the woman who is able to use her developed religious supports.[9]

All of these women can adjust to separations. If families anticipate separation and plan ahead, they are in an even better position to thrive during the father's absence.

Characteristics of Vulnerable Families

What vulnerabilities lead to failures in adaptation? The list is long and varied. At times, several factors may be involved in a single failure.[11] Some causes are as follows:

1) Youth and inexperience — very young couples with limited familiarity with the military;
2) Long delays and uncertainty regarding deployment dates and details;
3) A recent move from one base to another — the military family who just underwent one transition finds it hard to face another;
4) A move from base housing — the family forced to move from base housing because of the loss of the active duty member sometimes views the civilian community as a hostile world;
5) Diminished economic stability caused by the separation and loss of housing;
6) Limited supports both in the community and the command;
7) Lack of extended family support;
8) Pre-existing marital problems;
9) Seriously disturbed children;
10) An autocratic, rigid father, described as the pivotal figure in "The Military Family Syndrome."[12] The wife and children identify the father with the military. They recoil from both threats and unite to extrude the father from the family system. Although families of this type are considered vulnerable, they often do better during separations if internally strong;
11) A wife who is encouraged by her husband prior to separation to become upset and ill so as to necessitate his return to her side;
12) A wife resistant to the idea of seeking help, support and treatment — she remains isolated;
13) A wife who has poor communication skills;
14) A "psychologic father presence" — the family still considers the father present even after separation. In spite of his departure, the mother encourages talking and thinking about father as if he were spiritually present. Not only does this create an ambiance of unreality but strongly impairs the development of an enhanced maternal role so vital for adaptation.[14]

Re-Integration — the Reunion of the Father With His Family

The return to family life is so often stressful for the father. His children are older and may be underdisciplined, their behavior worsening when he reenters the picture. His wife, too, may have changed and become more independent. Added to these anxieties is the question of faithfulness, which may loom large in the minds of both marital partners. All factors considered, the father is apt to feel overwhelmed by the obligations of family life, especially since a general feeling of unfamiliarity may obscure his perception of his family's needs.[13]

The family also sees the father as different, changed, somehow grown. The wife may be unprepared to relinquish her new found independence. But, as in the case of the father's departure, such stresses can be growth fostering once they are satisfactorily resolved.

Re-integration tends to go better if all the parties involved expect adjustment and have an open communication pattern — if they have kept in touch during the separation by phone calls and letters. If the husband and wife have had a long marriage, are affectionate and have mutual interests, the chances of a smooth reunion are also increased. If a man is patient, not brusque, and is willing to win back his family's love, he is more likely to recover his role as father. A successful family is one for whom the

family's well-being takes precedence over the individual needs of its members.[14]

Suggestions

Above all, work towards building and maintaining a strong family unit. Anticipate and prepare for separations, talk about them in detail. The wife should prepare for sex role flexibility — to be a mother and a father to her children. Her children and husband should assist her in the establishment of this role. Consider the use of father surrogates, individuals who might serve as father figures for the children. Also consider extended family involvement, but be mindful of its drawbacks. Relationships established during the father's absence should not become liabilities upon his return. Correspond as frequently as possible with the father during the separation. Explore community support systems; innovative programs do exist which should be known of and publicized by the command. If the need arises, don't hesitate to seek professional help.

A family system capable of change, willing to try something new, tends to adjust well to the separation.

And finally, be mindful of the re-integration process — "go easy." Use both separations and reunions to temper family strength. They need not be feared and destructive forces in military family life.

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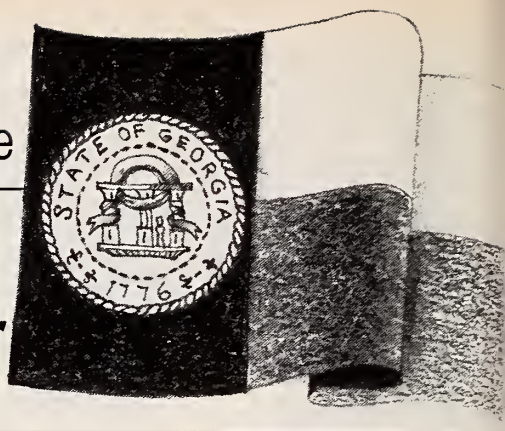
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One of the most important discoveries in medicine was the use of ether in surgical procedures, and its revelation was delayed because of the inordinate modesty of Dr. Crawford W. Long, its first successful user.

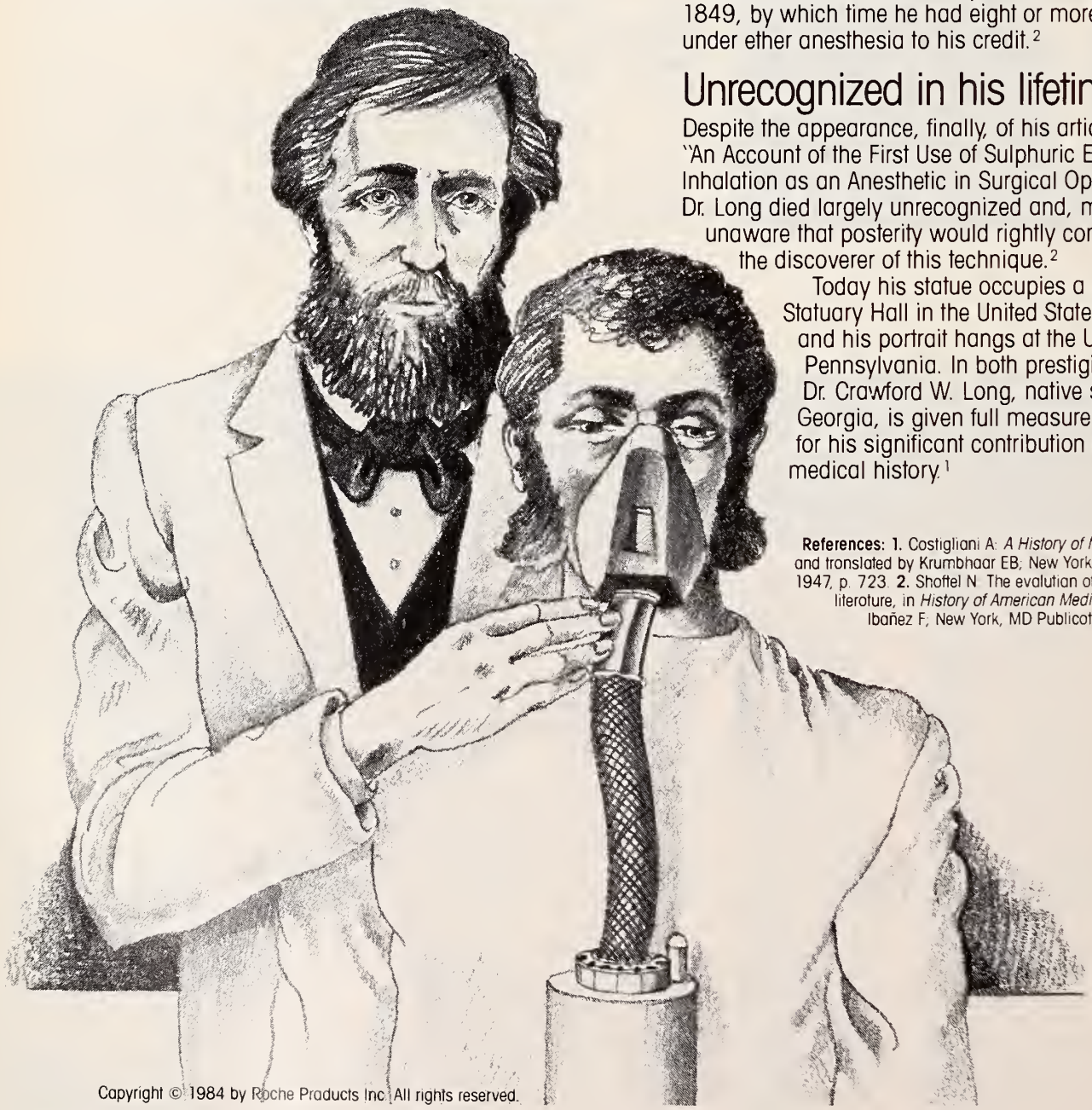
A simple country practitioner in Jefferson, Georgia, Dr. Long had little surgical experience when, on March 30, 1842, he experimented with the use of sulfuric ether as an anesthetic in the surgical removal of a small septic tumor from the neck of a patient. The patient, James Venable, reported feeling no pain during the incision and removal proceedings, and soon recovered.[1,2]

Pleased by the results of surgery under anesthesia, Dr. Long continued to use ether in surgery and obstetrics. Recognition for his accomplishment was limited, however, because he did not publish his discovery until 1849, by which time he had eight or more operations under ether anesthesia to his credit.[2]

Unrecognized in his lifetime

Despite the appearance, finally, of his article titled "An Account of the First Use of Sulphuric Ether by Inhalation as an Anesthetic in Surgical Operations," Dr. Long died largely unrecognized and, most assuredly, unaware that posterity would rightly consider him the discoverer of this technique.[2]

Today his statue occupies a place in Statuary Hall in the United States Capitol, and his portrait hangs at the University of Pennsylvania. In both prestigious locations, Dr. Crawford W. Long, native son of Georgia, is given full measure of respect for his significant contribution to medical history.[1]



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When the history reveals mixed depression and anxiety...

For the estimated 70 percent of nonpsychotic depressed patients who are also anxious,[1] Limbitrol provides both amitriptyline, specific for symptoms of depression, and the effects of Librium® (chlordiazepoxide HCl/Roche), the tested and dependable anxiolytic. Limbitrol is, therefore, a better choice for these patients than dual agents that contain a phenothiazine, a class of antipsychotic drugs which has been associated with tardive dyskinesia.

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Limbitrol also has a rapid onset of action which may lead to greater patient compliance. In a multicenter study, patients taking Limbitrol experienced 62% of their overall improvement within the first week of therapy.[2]

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- ☐ Headache—79%
- ☐ Early insomnia—91%
  Middle insomnia—87%
  Late insomnia—89%
- ☐ Gastrointestinal upset—73%

In two multicenter studies, only 1.9% of Limbitrol patients experienced cardiovascular side effects.[3]

Patients should be cautioned about the combined effects with alcohol or other CNS depressants and about activities requiring complete mental alertness such as operating machinery or driving a car.

References: 1. Rickels K: Drug treatment of anxiety, in *Psychophormocology in the Proctice of Medicine,* edited by Jarvik ME; New York, Appleton-Century-Crofts, 1977, p. 316. **2.** Feighner JP *et al: Psychophormocology 61:* 217-229, Mar 1979. **3.** Data on file, Hoffmann-La Roche Inc., Nutley, NJ.

In moderate depression and anxiety

Limbitrol® IV

Tablets 5-12.5 each containing 5 mg chlordiazepoxide and 12.5 mg amitriptyline (as the hydrochloride salt)
Tablets 10-25 each containing 10 mg chlordiazepoxide and 25 mg amitriptyline (as the hydrochloride salt)

Please see summary of product information on following page.

LIMBITROL® Tablets Ⓝ Tranquilizer–Antidepressant

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Relief of moderate to severe depression associated with moderate to severe anxiety.

Contraindications: Known hypersensitivity to benzodiazepines or tricyclic antidepressants. Do not use with monoamine oxidase (MAO) inhibitors or within 14 days following discontinuation of MAO inhibitors since hyperpyretic crises, severe convulsions and deaths have occurred with concomitant use; then initiate cautiously, gradually increasing dosage until optimal response is achieved. Contraindicated during acute recovery phase following myocardial infarction.

Warnings: Use with great care in patients with history of urinary retention or angle-closure glaucoma. Severe constipation may occur in patients taking tricyclic antidepressants and anticholinergic-type drugs. Closely supervise cardiovascular patients. (Arrhythmias, sinus tachycardia and prolongation of conduction time reported with use of tricyclic antidepressants, especially high doses. Myocardial infarction and stroke reported with use of this class of drugs.) Caution patients about possible combined effects with alcohol and other CNS depressants and against hazardous occupations requiring complete mental alertness (*e.g.*, operating machinery, driving).

Usage in Pregnancy: **Use of minor tranquilizers during the first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.**

Since physical and psychological dependence to chlordiazepoxide have been reported rarely, use caution in administering Limbitrol to addiction-prone individuals or those who might increase dosage; withdrawal symptoms following discontinuation of either component alone have been reported (nausea, headache and malaise for amitriptyline; symptoms [including convulsions] similar to those of barbiturate withdrawal for chlordiazepoxide).

Precautions: Use with caution in patients with a history of seizures, in hyperthyroid patients or those on thyroid medication, and in patients with impaired renal or hepatic function. Because of the possibility of suicide in depressed patients, do not permit easy access to large quantities in these patients. Periodic liver function tests and blood counts are recommended during prolonged treatment. Amitriptyline component may block action of guanethidine or similar antihypertensives. Concomitant use with other psychotropic drugs has not been evaluated; sedative effects may be additive. Discontinue several days before surgery. Limit concomitant administration of ECT to essential treatment. See Warnings for precautions about pregnancy. Limbitrol should not be taken during the nursing period. Not recommended in children under 12. In the elderly and debilitated, limit to smallest effective dosage to preclude ataxia, oversedation, confusion or anticholinergic effects.

Adverse Reactions: Most frequently reported are those associated with either component alone: drowsiness, dry mouth, constipation, blurred vision, dizziness and bloating. Less frequently occurring reactions include vivid dreams, impotence, tremor, confusion and nasal congestion. Many depressive symptoms including anorexia, fatigue, weakness, restlessness and lethargy have been reported as side effects of both Limbitrol and amitriptyline. Granulocytopenia, jaundice and hepatic dysfunction have been observed rarely.

The following list includes adverse reactions not reported with Limbitrol but requiring consideration because they have been reported with one or both components or closely related drugs:

Cardiovascular: Hypotension, hypertension, tachycardia, palpitations, myocardial infarction, arrhythmias, heart block, stroke.

Psychiatric: Euphoria, apprehension, poor concentration, delusions, hallucinations, hypomania and increased or decreased libido.

Neurologic: Incoordination, ataxia, numbness, tingling and paresthesias of the extremities, extrapyramidal symptoms, syncope, changes in EEG patterns.

Anticholinergic: Disturbance of accommodation, paralytic ileus, urinary retention, dilatation of urinary tract.

Allergic: Skin rash, urticaria, photosensitization, edema of face and tongue, pruritus.

Hematologic: Bone marrow depression including agranulocytosis, eosinophilia, purpura, thrombocytopenia.

Gastrointestinal: Nausea, epigastric distress, vomiting, anorexia, stomatitis, peculiar taste, diarrhea, black tongue.

Endocrine: Testicular swelling and gynecomastia in the male, breast enlargement, galactorrhea and minor menstrual irregularities in the female, elevation and lowering of blood sugar levels, and syndrome of inappropriate ADH (antidiuretic hormone) secretion.

Other: Headache, weight gain or loss, increased perspiration, urinary frequency, mydriasis, jaundice, alopecia, parotid swelling.

Overdosage: Immediately hospitalize patient suspected of having taken an overdose. Treatment is symptomatic and supportive. I.V. administration of 1 to 3 mg physostigmine salicylate has been reported to reverse the symptoms of amitriptyline poisoning. See complete product information for manifestation and treatment.

Dosage: Individualize according to symptom severity and patient response. Reduce to smallest effective dosage when satisfactory response is obtained. Larger portion of daily dose may be taken at bedtime. Single *h.s.* dose may suffice for some patients. Lower dosages are recommended for the elderly.

Limbitrol 10-25, initial dosage of three or four tablets daily in divided doses, increased up to six tablets or decreased to two tablets daily as required. Limbitrol 5-12.5, initial dosage of three or four tablets daily in divided doses, for patients who do not tolerate higher doses.

How Supplied: White, film-coated tablets, each containing 10 mg chlordiazepoxide and 25 mg amitriptyline (as the hydrochloride salt) and blue, film-coated tablets, each containing 5 mg chlordiazepoxide and 12.5 mg amitriptyline (as the hydrochloride salt)—bottles of 100 and 500; Tel-E-Dase® packages of 100; Prescription Paks of 50.

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BRIEF SUMMARY

PROCARDIA® (nifedipine) **CAPSULES** For Oral Use

INDICATIONS AND USAGE: I. Vasospastic Angina: PRDCARDIA (nifedipine) is indicated for the management of vasospastic angina confirmed by any of the following criteria: 1) classical pattern of angina at rest accompanied by ST segment elevation, 2) angina or coronary artery spasm provoked by ergonovine, or 3) angiographically demonstrated coronary artery spasm. In those patients who have had angiography, the presence of significant fixed obstructive disease is not incompatible with the diagnosis of vasospastic angina, provided that the above criteria are satisfied. PRDCARDIA may also be used where the clinical presentation suggests a possible vasospastic component but where vasospasm has not been confirmed, e.g., where pain has a variable threshold on exertion or in unstable angina where electrocardiographic findings are compatible with intermittent vasospasm, or when angina is refractory to nitrates and or adequate doses of beta blockers.

II. Chronic Stable Angina (Classical Effort-Associated Angina): PRDCARDIA is indicated for the management of chronic stable angina (effort-associated angina) without evidence of vasospasm in patients who remain symptomatic despite adequate doses of beta blockers and or organic nitrates or who cannot tolerate those agents.

In chronic stable angina (effort-associated angina) PRDCARDIA has been effective in controlled trials of up to eight weeks duration in reducing angina frequency and increasing exercise tolerance, but confirmation of sustained effectiveness and evaluation of long-term safety in those patients are incomplete.

Controlled studies in small numbers of patients suggest concomitant use of PRDCARDIA and beta blocking agents may be beneficial in patients with chronic stable angina, but available information is not sufficient to predict with confidence the effects of concurrent treatment, especially in patients with compromised left ventricular function or cardiac conduction abnormalities. When introducing such concomitant therapy, care must be taken to monitor blood pressure closely since severe hypotension can occur from the combined effects of the drugs. (See Warnings.)

CONTRAINDICATIONS: Known hypersensitivity reaction to PRDCARDIA.

WARNINGS: Excessive Hypotension: Although in most patients, the hypotensive effect of PRDCARDIA is modest and well tolerated, occasional patients have had excessive and poorly tolerated hypotension. These responses have usually occurred during initial titration or at the time of subsequent upward dosage adjustment, and may be more likely in patients on concomitant beta blockers.

Severe hypotension and or increased fluid volume requirements have been reported in patients receiving PRDCARDIA together with a beta blocking agent who underwent coronary artery bypass surgery using high dose fentanyl anesthesia. The interaction with high dose fentanyl appears to be due to the combination of PRDCARDIA and a beta blocker, but the possibility that it may occur with PRDCARDIA alone, with low doses of fentanyl, in other surgical procedures, or with other narcotic analgesics cannot be ruled out. In PROCARDIA treated patients where surgery using high dose fentanyl anesthesia is contemplated, the physician should be aware of these potential problems and if the patient's condition permits, sufficient time (at least 36 hours) should be allowed for PRDCARDIA to be washed out of the body prior to surgery.

Increased Angina: Occasional patients have developed well documented increased frequency, duration or severity of angina on starting PRDCARDIA or at the time of dosage increases. The mechanism of this response is not established but could result from decreased coronary perfusion associated with decreased diastolic pressure with increased heart rate, or from increased demand resulting from increased heart rate alone.

Beta Blocker Withdrawal: Patients recently withdrawn from beta blockers may develop a withdrawal syndrome with increased angina, probably related to increased sensitivity to catecholamines. Initiation of PRDCARDIA treatment will not prevent this occurrence and might be expected to exacerbate it by provoking reflex catecholamine release. There have been occasional reports of increased angina in a setting of beta blocker withdrawal and PRDCARDIA initiation. It is important to taper beta blockers if possible, rather than stopping them abruptly before beginning PROCARDIA.

Congestive Heart Failure: Rarely patients, usually receiving a beta blocker, have developed heart failure after beginning PRDCARDIA. Patients with tight aortic stenosis may be at greater risk for such an event.

PRECAUTIONS: General: Hypotension: Because PRDCARDIA decreases peripheral vascular resistance, careful monitoring of blood pressure during the initial administration and titration of PRDCARDIA is suggested. Close observation is especially recommended for patients already taking medications that are known to lower blood pressure. (See Warnings.)

Peripheral edema: Mild to moderate peripheral edema, typically associated with arterial vasodilation and not due to left ventricular dysfunction, occurs in about one in ten patients treated with PRDCARDIA. This edema occurs primarily in the lower extremities and usually responds to diuretic therapy. With patients whose angina is complicated by congestive heart failure, care should be taken to differentiate this peripheral edema from the effects of increasing left ventricular dysfunction.

Drug Interactions: Beta-adrenergic blocking agents: (See Indications and Warnings.) Experience in over 1400 patients in a non-comparative clinical trial has shown that concomitant administration of PRDCARDIA and beta-blocking agents is usually well tolerated, but there have been occasional literature reports suggesting that the combination may increase the likelihood of congestive heart failure, severe hypotension or exacerbation of angina.

Long-acting nitrates: PRDCARDIA may be safely co-administered with nitrates, but there have been no controlled studies to evaluate the antianginal effectiveness of this combination.

Digitalis: Administration of PRDCARDIA with digoxin increased digoxin levels in nine of twelve normal volunteers. The average increase was 45%. Another investigator found no increase in digoxin levels in thirteen patients with coronary artery disease. In an uncontrolled study of over two hundred patients with congestive heart failure during which digoxin blood levels were not measured, digitalis toxicity was not observed. Since there have been isolated reports of patients with elevated digoxin levels, it is recommended that digoxin levels be monitored when initiating, adjusting, and discontinuing PRDCARDIA to avoid possible over- or under-digitalization.

Carcinogenesis, mutagenesis, impairment of fertility: When given to rats prior to mating, nifedipine caused reduced fertility at a dose approximately 30 times the maximum recommended human dose.

Pregnancy: Category C. Please see full prescribing information with reference to teratogenicity in rats, embryotoxicity in rats, mice and rabbits, and abnormalities in monkeys.

ADVERSE REACTIONS: The most common adverse events include dizziness or light-headedness, peripheral edema, nausea, weakness, headache and flushing each occurring in about 10% of patients; transient hypotension in about 5%, palpitation in about 2% and syncope in about 0.5%. Syncopal episodes did not recur with reduction in the dose of PRDCARDIA or concomitant antianginal medication. Additionally, the following have been reported: muscle cramps, nervousness, dyspnea, nasal and chest congestion, diarrhea, constipation, inflammation, joint stiffness, shakiness, sleep disturbances, blurred vision, difficulties in balance, dermatitis, pruritus, urticaria, fever, sweating, chills, and sexual difficulties. Very rarely, introduction of PRDCARDIA therapy was associated with an increase in anginal pain, possibly due to associated hypotension.

In addition, more serious adverse events were observed, not readily distinguishable from the natural history of the disease in these patients. It remains possible, however, that some or many of these events were drug related. Myocardial infarction occurred in about 4% of patients and congestive heart failure or pulmonary edema in about 2%. Ventricular arrhythmias or conduction disturbances each occurred in fewer than 0.5% of patients.

Laboratory Tests: Rare, mild to moderate, transient elevations of enzymes such as alkaline phosphatase, CPK, LDH, SGOT, and SGPT have been noted, and a single incident of significantly elevated transaminases and alkaline phosphatase was seen in a patient with a history of gall bladder disease after about eleven months of nifedipine therapy. The relationship to PRDCARDIA therapy is uncertain. These laboratory abnormalities have rarely been associated with clinical symptoms. Cholestasis, possibly due to PRDCARDIA therapy, has been reported twice in the extensive world literature.

HOW SUPPLIED: Each orange, soft gelatin PRDCARDIA CAPSULE contains 10 mg of nifedipine. PRDCARDIA CAPSULES are supplied in bottles of 100 (NDC 0069-2600-66), 300 (NDC 0069-2600-72), and unit dose (10x10) (NDC 0069-2600-41). The capsules should be protected from light and moisture and stored at controlled room temperature 59° to 77°F (15° to 25°C) in the manufacturer's original container.

More detailed professional information available on request

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Quotes from an unsolicited letter received by Pfizer from an angina patient. While this patient's experience is representative of many unsolicited comments received, not all patients will respond to Procardia nor will they all respond to the same degree.

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1) Confirmed vasospastic angina.
2) Angina where the clinical presentation suggests a possible vasospastic component.
3) Chronic stable angina without evidence of vasospasm in patients who remain symptomatic despite adequate doses of beta blockers and/or nitrates or who cannot tolerate these agents. In chronic stable angina (effort-associated angina) PROCARDIA has been effective in controlled trials of up to eight weeks' duration in reducing angina frequency and increasing exercise tolerance, but confirmation of sustained effectiveness and evaluation of long-term safety in these patients are incomplete.

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J-4044 January 1984

The author outlines the problems and costs involved in medical malpractice and discusses some practical solutions.

Medical Malpractice in Georgia — 1984

JEFFREY T. NUGENT, M.D., *Atlanta**

MAJOR REASONS for runaway medical care costs are increased patient demands, higher technology for both testing and treatment modes for our patients, government interference in the form of increasing regulation and monetary manipulation causing inflation and, finally, defensive medicine and malpractice insurance costs. Perhaps the least understood and least appreciated serious cost is defensive medicine.

Since 1977, the frequency of claims in Georgia has doubled from 7.9 to 15.9 claims per 100 physicians. . . .

Since by definition a competent physician is one who practices quality medicine as well as one who avoids law suits, defensive medicine has become a part of the practice of all physicians. It is both an attitude and an action plan which can interfere with a proper doctor-patient relationship and can lead to overtesting and in some cases overtreatment; and it surely costs billions. The Georgia Governor's Advisory Council on Medical Malpractice, in its January 1984 report to Governor Joe Frank Harris, estimated that 30% of the nation's cost of medical care may be directly or indirectly attributed to the medical malpractice problem. They estimated that the malpractice cost to Georgia citizens was 3 billion dollars in 1983.

At first blush, it seems ridiculous that this percentage of the cost of medical care might be attributed to defensive medicine and malpractice. However, if one simply adds up the number of x-rays which are taken primarily for this reason, the amount of paper work involved in current style of medical records in addition to correspondence with attorneys and others, extra testing that is done in order to be "extremely safe" in making a diagnosis, overtreatment to satisfy each patient's every whim, etc., one can quickly see that this is not an unreasonable estimate. Although the general cost of medical malpractice insurance alone is approximately 3½% of gross income for physicians throughout the United States, in certain locations such as Florida, California and New York, it may approach 15 to 20% of gross income for certain practitioners.

In Georgia, we are witnessing a definite increase in claims against physicians and remarkably larger jury awards with proportional increases in our professional liability coverage costs. Since 1977, the frequency of claims in Georgia has doubled from 7.9 to 15.9 claims per 100 physicians, and the "severity" of the claims has increased 500% to 600%. Since 1981, we have seen 10 awards and settlements for over 1 million dollars per claim in this state, and according to MAG Mutual, 88% of our neurosurgeons, 71% of our anesthesiologists, and 60% of our orthopaedists and chest surgeons carry insurance coverage in excess of 1 million dollars per claim. Everyone asks privately if it's enough.

We must follow carefully what happens this year in Florida, which currently leads the nation in size of jury awards and number of verdicts greater than 1 million dollars. The Florida Medical Association is going public to ask for support of "tort reform" (changes in law or rules which apply to civil litigation), because of several factors including: (1) the vindictive nature of the tort system with untold dis-

* Dr. Nugent, an orthopedic surgeon, is President of the Medical Association of Atlanta. This article is reprinted from the May 1984 issue of *Atlanta Medicine*.

tress for those doctors falsely accused of malpractice; (2) the detrimental effect of this problem on the patient-physician relationship and the practice of medicine; (3) the apparent injustice of a system which returns more than 50% of the money to defense and plaintiff lawyers; and (4) huge increases in the cost of malpractice insurance which significantly affects physicians' incentives in high risk specialties. As an example, obstetricians in Miami, Florida, pay $50,000 per year for standard 1 million dollar per claim insurance. New physicians in practice are facing an overwhelming policy premium. The older physicians are wanting to get out of obstetrics or retire early. As expected, the Florida Trial Lawyers Association is providing strong opposition to the doctors' project; however, the Florida Medical Association plans to gain widespread publicity with the money gained from a $300 per member assessment. The Florida Medical Association was greatly disappointed by the lack of interest in the malpractice package ignored by the Florida legislature this past year.

The Governor's Council on Malpractice has recommended other immediate measures including limitation on rewards for non-economic losses, structured settlements for larger awards, and sovereign immunity for certain teaching hospitals.

In Georgia, two bills were pushed by MAG and MAG Mutual which succeeded in passing the 1984 legislature. One was H.B. 1276 concerning peer review immunity, and the second was H.B. 1230 concerning jury exemptions. However, S.B. 329, an important one concerning tort reform, never came out of the House Judiciary Committee. The Governor's Council on Malpractice has recommended other immediate measures including limitation on rewards for non-economic losses, structured settlements for larger awards, and sovereign immunity for certain teaching hospitals. They have further recommended a study of pre-screening panels; the "loser pays all costs" concept; a constitutional amendment to make special rules for malpractice cases; limitation of legal contingency fees; and other measures. These ideas are good ones, and we should press for the governor and the legislature to seriously consider these measures next year.

The Risk Management Seminars which were initially a joint project of the Medical Association of Georgia and St. Paul Insurance Company primarily sought to educate physicians as to the magnitude of the problem and to assist them in providing quality practice with accurate documentation in the medical record. MAG Mutual and MAG will soon be conducting a phase II program to give specific information to specialists regarding risk management. Also, they will conduct medical education programs for medical assistants. MAG Mutual Insurance has brought competition in malpractice coverage to our state, and we see from their leadership the determined effort to fight frivolous claims "tooth and nail."

The 1982 AMA public opinion survey found that a plurality of Americans thought juries awarded too much money; 62% felt there should be some limit to the awards.

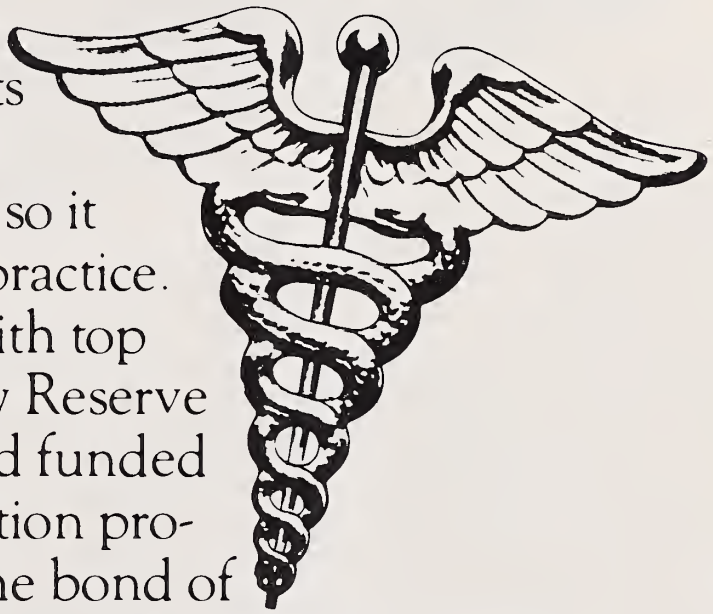
The 1982 AMA public opinion survey found that the majority of Americans definitely wanted to retain their right to sue anyone if they wish. Yet, in 1983, the Kane-Parsons AMA public opinion survey found that a plurality of its sample felt that malpractice plaintiffs were "just looking for a way to make money." A similar plurality thought that juries awarded too much money. Sixty-two percent felt that there should be some limit to the awards. One might conclude that now is the time that the public would be quite sensitive to tort reform or some changes in the legal method which handles this type of litigation.

I believe that the public as well as the leaders of business and the legal profession should work together more on this problem. Lawyers and other professionals are getting sued more frequently now and there is no reason to believe that a legal malpractice climate won't skyrocket much as we have seen in medical malpractice. The product liability suits and other types of measures brought before the civil courts are increasingly adding to the expense of everything we buy. Maybe it's not costing enough for everyone to be alarmed here as is evident in Miami.

Georgia doctors are going to have to dig deeper into their pockets to pay for insurance in 1984, and our patients are going to have to finance the cost of defensive medicine plus premiums until an equitable solution is found. We live in a society which greatly appreciates our well trained and conscientious physicians; it is a miserable charge by malpractice attorneys that "doctors better clean up their act and eliminate negligence" before trial lawyers will bend an inch.

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editorial
editorial
editorial

Who Needs Leadership?

Most of those who know me well know that I get a great kick out of participating in politics. If it had not taken so much time to serve, I probably would have run for some office in the past. Fortunately, I am now mature enough to stand on the sidelines and simply help others get elected.

Until last year, I had never been to one of the Legislative Conferences sponsored by MAG. As a member of the Executive Committee of MAG Mutual, however, I was told to go last year. To my surprise, it was a most meaningful experience, and I would like to praise its effectiveness.

A lot of doctors do not really understand how politics works. They call on someone when they need something, but they have never prepared the way for a warm reception.

The politician really needs you when he is running for office. If you will work for him, contribute for him, and help get out the vote for him, he will remember you in your time of need. Several of our legislators were too shy to point this out last year, but it was very clearly pointed out in our conferences that they remember the people who put them in office. If you help someone get elected, they will sit down and talk with you about your problems. This is something that doctors learn by going to the Legislative Conference.

Last year's chief topic of conversation was the informed consent problem; several legislators there felt that Georgia's law needed changing. Before we left the Conference, we had a tremendous impact on their opinion by discussing this with them in an intelligent manner. The effectiveness of this meeting alone made a tremendous difference in our ability to retain our present law. This made the whole Conference worthwhile. This year's Conference will be held on August 24-26 at Hilton Head Island, South Carolina, and I encourage you to go. We physicians have been silent too long in the political forum. We need to be more active, not only at the national level with AMPAC and at the state level with GaMPAC but also at the local level. The physician who lives across the street from the legislator, who plays golf with him, or who serves on the church board with him is someone he trusts. We need to get these local doctors involved in the political process on a local level. We will then be unbeatable.

Let me encourage you to arrange your schedule so that you can attend the Legislative Conference from August 24-26, 1984, at Hilton Head Island. I promise you that you will have a good time, and I promise you that MAG will show you how politics can be fun as well as effective.

John P. Heard, M.D.
Family Practice, Decatur

legal page
legal page
legal page

Hospital Liability Under the Theory of Independent Corporate Negligence

ROBERT B. BERG, *Atlanta**

For many years, it has been well-settled law in Georgia that a hospital may be liable for the negligent acts of its employees, including in particular the physician/employees who serve on the hospital's medical staff. Thus, under the doctrine of *respondeat superior,* the hospital with an unqualified or incompetent physician/employee may be found liable for damages resulting from the malpractice of that physician, just as any employer may be held liable for the negligent acts of its employees.[1]

In most cases, however, a physician is an independent contractor, rather than a direct employee of the hospital, and it is the physician — and not the hospital — who both controls the manner and method in which he or she renders medical services and bears responsibility for the negligent performance of those services. "Ordinarily, a physician or surgeon on the staff of a hospital is not an employee of such hospital, and in the absence of allegations . . . that the hospital undertook to direct [the physician] in the way and manner of treating the patient, the hospital is not liable for the mere negligent performance of professional services by a physician or surgeon on its staff."[2] This does not mean, unfortunately, that the hospital is absolved of all liability for the acts of the non-employee physicians on its staff: Even when the physician is an independent contractor, the hospital still may be liable, under the theory of "independent corporate negligence," for allowing an unqualified or incompetent physician to practice medicine in the hospital. Thus, the person injured by the negligence of a non-employee physician may have a choice between two causes of action: If the physician is an employee of the hospital, the patient may sue the hospital under the doctrine of *respondeat superior;* even if not, the patient may sue the hospital for its negligence in granting staff privileges to that physician.

Until recently, a patient usually could get to a jury in a lawsuit against the hospital simply by alleging that the hospital was negligent in granting staff privileges to the physician. A recent case[3] decided by the Georgia Court of Appeals, however, appears to have made it much more difficult for the patient to do so. This case is the subject of this month's Legal Page.

Hospital Liability for Independent Corporate Negligence

The theory that a hospital could be found negligent for granting staff privileges to an unqualified or incompetent physician, separate and apart from any liability,

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* Prepared at the request of the Medical Association of Georgia. Mr. Berg is an associate in the firm of Powell, Goldstein, Frazer & Murphy, General Counsel to the Association, 1100 C & S National Bank Building, Atlanta, GA 30335.

under the doctrine of *respondeat superior,* for the negligence of a physician directly employed by the hospital, was first recognized by a Georgia court in 1971, in *Joiner v. Mitchell County Hospital Authority*.[4] In that case, the plaintiff's husband, complaining of chest pains, was taken to the defendant hospital, where he was examined by a physician who advised the patient that his condition was not serious and that hospitalization was not required. About one and a half hours later, the patient's chest pains became more severe, and he died during his return trip to the hospital.

The plaintiff then filed a lawsuit against the hospital, alleging that the hospital was negligent in failing to require satisfactory proof of the professional qualifications of the physician, that it was negligent in failing to make any investigation into his qualifications, character, or background; and that it was negligent in failing to exercise care in determining his professional competency and moral character. The trial court granted summary judgment for the defendant hospital, holding that, as a matter of law, the hospital had absolved itself of liability in connection with its action in granting staff privileges to the physician by establishing that the physician was licensed to practice medicine by the State of Georgia and was recommended by the other physicians on the medical staff.

On appeal, the Georgia Court of Appeals reversed the trial court's judgment, finding that the hospital had a duty to act in good faith and with reasonable care in the selection of a physician and to screen applicants for positions on its medical staff, and that the hospital could not be said to have discharged that duty, as a matter of law, solely by showing that the physician was licensed and recommended by members of the medical staff. Thus, the Court held that:

> The mere fact that [the physician] was a licensed physician of the State of Georgia recommended by the other doctors on the staff as required by law does not overcome the averments that the hospital was negligent in failing to exercise care in determining his professional competency, should it later appear by evidence that the doctor was an incompetent or unskilled physician.[5]

On further appeal, the Georgia Supreme Court affirmed the decision of the Court of Appeals, finding that the issue of the hospital's negligence in allowing the physician to practice on its staff was a question of fact for the jury. "If the physician was incompetent and the [hospital] knew, or from information in its possession such incompetency was apparent, then it cannot be said that the [hospital] acted in good faith and with reasonable care in permitting the physician to become a member of its staff."[6] In fact, the Court likened the hospital's negligence "to that of the owner of a motor vehicle permitting an incompetent, inexperienced, or reckless driver to operate such motor vehicle."[7]

The *Joiner* case posed a particularly difficult problem for hospitals sued as the result of the negligent actions of physicians on their staffs. On the one hand, the hospital benefitted from establishing that the physician was an independent contractor, rather than an employee, since the hospital could thereby obtain summary judgment in defending an action under the *respondeat superior* doctrine. However, if the plaintiff also alleged that the hospital was negligent in allowing the independent contractor/physician to obtain staff privileges, the hospital would still be forced to defend the case at trial, unless it could establish, as a matter of law, that it acted reasonably and in good faith in granting staff privileges to that physician — a difficult task, in light of the *Joiner* Court's refusal to accept the physician's licensure and the recommendations of the medical staff as conclusive evidence.

Compliance with JCAH Standards as Conclusive Evidence of Good Faith

A recent case decided by the Georgia Court of Appeals, however, may have eliminated, or at least substantially reduced, the extent of the hospital's dilemma. In that case, an action was brought against a physician and the hospital at which the physician practiced, seeking recovery against the physician for medical malprac-

tice and against the hospital under the theory of independent corporate negligence. The hospital, in its defense of the action, introduced the affidavit of its executive director, showing that the hospital, in granting staff privileges to the defendant physician, had followed the standards and procedures set forth by the Joint Commission on the Accreditation of Hospitals (JCAH). Thus, at the time the physician had applied for staff privileges, the hospital had required and received satisfactory proof of the physician's professional qualifications as a practicing physician; it had also required and received references from the physician's medical and personal life, and had contacted those references. Further, the hospital had thereafter reviewed the physician's qualifications annually as a part of the hospital's staff privileges reappointment process.

In light of this evidence, the trial court granted summary judgment for the hospital, finding that it had established conclusively that it had acted reasonably and in good faith in granting staff privileges to the defendant physician. On appeal, the Georgia Court of Appeals agreed, finding that the hospital's evidence showing compliance with the applicable JCAH standards, together with the absence of any evidence suggesting that the hospital undertook to direct the way or manner in which the physician treated the plaintiff, conclusively absolved the hospital of liability. As stated by the Court:

> Under these circumstances, the trial court did not err in finding that [the hospital] had conclusively shown that it had acted in good faith and with reasonable care in appointing [the physician] to its medical staff and thus was entitled to judgment as a matter of law.[8]

Conclusion

In a purely legal sense, the Court of Appeals' decision does not change the law in Georgia, as it relates to a hospital's potential liability under the theory of independent corporate negligence — a hospital may still be found liable for failing to act in good faith and with reasonable care in granting staff privileges applications. As a practical matter, however, the Court of Appeals' decision makes it substantially more difficult for a plaintiff to reach a jury on that issue, since it appears that the plaintiff, in order to do so, must do more than merely allege that the hospital acted negligently; instead, the plaintiff specifically must refute a showing by the hospital that it complied with the applicable JCAH standards.

[Decisions rendered by the Georgia Court of Appeals are subject to appeal to the Supreme Court of Georgia, which has the power to affirm or to reverse the decision of the Georgia Court of Appeals, in whole or in part, with or without comment. Accordingly, it is possible that the opinion discussed in this article, although representing the current state of the law in Georgia, may be substantially altered or modified by the Supreme Court. In the event that the case discussed in this article is appealed and subsequently reversed by the Georgia Supreme Court, we will inform you of that decision, once it is reached, in a subsequent issue of the Journal.]

Notes

1. See, e.g., *Newton County Hospital v. Nickolson*, 132 Ga. App. 164, 166 (1974) ("(a) hospital owes a duty of reasonable care to its patients, and it is liable for the injuries negligently inflicted upon its patients by . . . employees of the hospital."); *Piedmont Hospital v. Anderson*, 65 Ga. App. 491 (1941); *Hospital Authority of City of Marietta v. Misfeldt*, 99 Ga. App. 702(1) (1959).
2. *Newton County Hospital v. Nickolson, supra*, 132 Ga. App. at 165-166.
3. *Sheffield v. Zilis*, ___ Ga. App. ___ (February 13, 1984).
4. 125 Ga. App. 1 (1971), *aff'd*, 229 Ga. 140 (1972).
5. *Joiner v. Mitchell County Hospital Authority, supra*, 125 Ga. App. at 3.
6. *Mitchell County Hospital Authority v. Joiner*, 229 Ga. 140, 143 (1972). It appears that Georgia courts are not alone in recognizing this type of cause of action; hospital liability for independent corporate negligence has been recognized by courts in several other states. See, generally, *Annotation*, 51 A.L.R. 3d 981 (1973).
7. *Id.*, 229 Ga. at 141-142.
8. *Sheffield v. Zilis, supra*, ___ Ga. App. at ___.

Diagnosing Coronary Artery Aneurysms in Patients with Mucocutaneous Lymph Node Syndrome (Kawasaki's Disease)

F. W. ARENSMAN, M.D., C. G. SHARP, M.D., W. COVITZ, M.D., and W. B. STRONG, M.D., *Augusta**

Abstract

Kawasaki's disease or Mucocutaneous Lymph Node Syndrome (MCLNS) is being reported with increasing frequency as Georgia physicians are increasingly aware of the clinical features of this entity. Fever and rash are such common symptoms that Kawasaki's disease may not be considered in the initial assessment and may be missed entirely if follow-up is incomplete. The lack of a specific diagnostic test for this disease compounds the problem of recognition and makes it imperative that physicians be familiar with the diagnostic criteria. The life-threatening complications of Kawasaki's disease usually occur after recovery from the acute phase of illness and are secondary to coronary aneurysms. These aneurysms complicate 20% of cases and will be unrecognized prior to rupture or myocardial infarction unless specifically sought for by cardiac ultrasound or angiography.

Introduction

In 1967, Kawasaki[1] was the first to describe mucocutaneous lymph node syndrome (MCLNS). The syndrome occurs primarily in infants and children and presents as an acute febrile illness with three clinical phases: acute, subacute, and convalescent.[2] The guidelines for diagnosis of MCLNS, formulated in 1972 by the Japanese Research Committee of MCLNS,[2] were based on Kawasaki's original description[1] and are provided in Figure 1. The committee requires that criterion #1 and at least three of the remaining four criteria be met for the diagnosis to be accepted.

The acute phase of MCLNS presents with fever, conjunctivitis, lymphadenopathy, and erythema (palms, soles, lips, and mouth). The acute phase usually lasts 1 to 2 weeks. The subacute phase begins with defervescence: anorexia, irritability, thrombocytosis, arthritis, myalgia, cardiac symptoms; desquamation of the hands and feet may be present. This phase may last 10 to 25 days from the onset of the syndrome. The cardiac signs and symptoms have been described by Kato[2, 4] as

* From the Section of Pediatric Cardiology, Department of Pediatrics, Medical College of Georgia. Send reprint requests to Frederick W. Arensman, M.D., Section of Pediatric Cardiology, Room BD-201, Medical College of Georgia, Augusta, GA 30912.

Articles for this Page are sponsored and approved by the American Heart Association, Georgia Affiliate. Those wishing to contribute papers to this Page are invited to send them to Dr. Laurence O. Watkins, Heart Page Editor, Section of Cardiology, Dept. of Medicine, MCG, Augusta, GA 30909.

MCLNS — Diagnostic Criteria

1) Fever lasting more than 5 days (not responsive to antibiotics)
2) Skin rash-polymorphous, nonvesicular, involving 1° the trunk
3) Erythema/edema of hands and/or feet
4) Nonsuppurative cervical lymphadenopathy ($\geq$1.5 cm)
5) Mucous membrane changes
   Soreness and/or cracking of the oral mucosa and tongue
6) Bilateral conjunctivitis

Figure 1 — Diagnostic criteria for MCLNS. With increasing awareness of the other features, refractoriness of the fever to antibiotics is probably not required.

gallop rhythm, apical systolic murmur, dysrhythmia, and shock. The convalescent phase lasts from the subacute phase until the erythrocyte sedimentation rate returns to normal.

Patients and Methods

In the last 5 years, 21 patients at the Medical College of Georgia were diagnosed as having MCLNS. The patients were either referred to our medical center with an acute febrile illness and subsequently diagnosed as having MCLNS or were sent to us for confirmation of MCLNS and cardiac evaluation. The mean age was 2.6 years (range 10 months to 5 years and 10 months). Fourteen of the patients (67%) were male. Seven patients were black, thirteen patients were white, and one patient was Oriental. This racial mix was different from our other admissions. Usually we see almost equal numbers of black and white patients, and only about 0.2% of our patients are Oriental.

Routine laboratory data included chest x-ray, 12 lead ECG, CBC with platelet count and sedimentation rate. Some patients had, in addition, evaluation of cardiac enzymes, blood cultures, and viral titers.

M-mode and two-dimensional echocardiograms were performed in the usual supine or left lateral position. An appropriate transducer was used. Routine 2-D echo views included parasternal long axis, short axis at the level of the mitral valve and aortic root, and subxiphoid four chamber view. Two-dimensional echocardiograms were recorded in all but two patients at 1 to 4 months after the onset of disease. Two patients had echocardiograms more than 1 year after onset of symptoms.

Cardiac catheterization was performed in the routine manner. Most patients had only left-sided catheterization, and angiography consisted of aortic root injection. By using at least 1 cc of contrast per kilogram of body weight and injecting just above the aortic valve, coronary artery anatomy was adequately defined. No patient underwent selective coronary artery injections.

Of the 21 patients, five (24%) were found to have at least one coronary artery aneurysm. In three of these five patients, aneurysms were easily detected on 2-D echocardiography. A fourth patient had an aneurysm which was initially missed on echocardiography. After the angiogram confirmed the presence of an aneurysm, the echo was repeated, and the aneurysm was visualized on echocardiography. In the fifth patient, the angiogram documented three large left coronary artery

aneurysms and numerous small ones, as well as one large right coronary artery aneurysm. On repeat echocardiography, the aneurysms still could not be visualized.

Seven of 19 patients had an abnormal ECG during the symptomatic phase or follow-up period. In four of the seven, ECG revealed left atrial enlargement and left ventricular hypertrophy. In thirteen patients with M-mode echocardiograms, 12 had dilatation of the left atrium, and nine had dilatation of the left ventricle. All 13 had normal ventricular function. There was no correlation between the degree of elevation of the ESR or platelet count and the presence of coronary artery aneurysms.

Discussion

The patient population in our series was similar to American[5, 6] and Japanese[7] groups previously reported; there was a predominance of young males. Coronary artery aneurysms have been reported in 8 to 55% of patients.[8] The risk of aneurysms may be higher in young patients with prolonged fever, elevated white blood count and sedimentation rate.[9] There are currently no satisfactory criteria for predicting in which patients aneurysms will develop.

Incidence of sudden death was 1-2%,[1, 8] and the mechanism of death was usually aneurysm related.[10] Autopsy studies have demonstrated thrombus formation which results in myocardial ischemia or infarction. Fatal arrhythmias may occur, and these may be related to ischemia secondary to aneurysm thrombosis.[10]

Because the etiology of Kawasaki's disease is unknown, we cannot alter factors or exposures which may predispose children to the disease. Once the disease has started, there is no known therapy to reduce the incidence or severity of aneurysms. One study has shown that intervention with steroids may actually increase the incidence of aneurysms.[11] Thus, the best management at this time is to reduce the complications attributable to aneurysms which have already formed.

Kato et al[11] have suggested that aspirin in low doses significantly reduced platelet aggregation and therefore *might* be effective in preventing thrombosis of an aneurysm. In a small group of children with aneurysms who received 30 mg/Kg of A.S.A. each day, no sudden deaths occurred. They therefore recommended that all children with Kawasaki's disease be treated with A.S.A. 30 mg/Kg for at least 2 months, the time interval in which sudden death most frequently occurs.

Though Kato et al have stated that angiography is the preferred method for diagnosing coronary aneurysms,[11] other authors have utilized 2-D subcostal echocardiography to demonstrate peripheral right coronary artery involvement.[12] This subcostal approach does not image normal right coronary arteries, but aneurysmally dilated vessels are easily seen. Many institutions have relegated angiography to a secondary role in the diagnosis of aneurysms. The rationale for this approach is that most aneurysms in Kawasaki's disease are proximal and are therefore visible on 2-D echo. Because the majority of aneurysms can be detected noninvasively (80%), the risk of angiography can be avoided.

Although we agree that *most* aneurysms are detected by 2-D echo, we have found that normal 2-D echo does not unequivocally rule out aneurysms (Figure 2). Other authors have reported both normal and abnormal M-mode and 2-D echocardiograms in those who develop aneurysms.[13] Specificity of echocardiography is low. We therefore have adopted the protocol illustrated in Figure 3.

Explanation of Flow Chart

The end-point for this protocol is angiographic demonstration of normal coronary arteries. Until we have proven by angiography that aneurysms are absent, we *assume* that they are present and undetected. The clinical impact of this decision is that all children remain on low dose aspirin until angiography excludes coronary artery involvement. At initial evaluation, all patients undergo a complete physical examination, a comprehensive cardiovascular exam including a search for femoral and axillary bruits. Initial laboratory examination includes PA and lateral chest

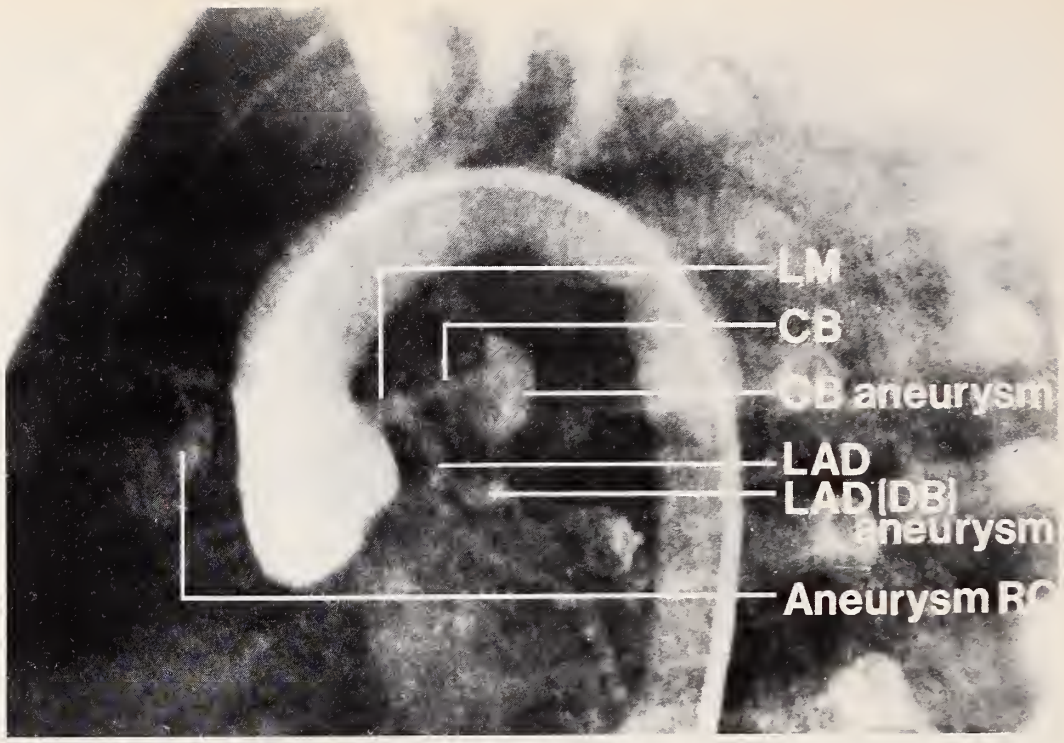


Figure 2 — Aortic root injection in the lateral projection showing normal proximal left coronary artery with distal aneurysms in a branch of the left anterior descending and circumflex arteries. These abnormalities were not visible on 2-D echocardiography.

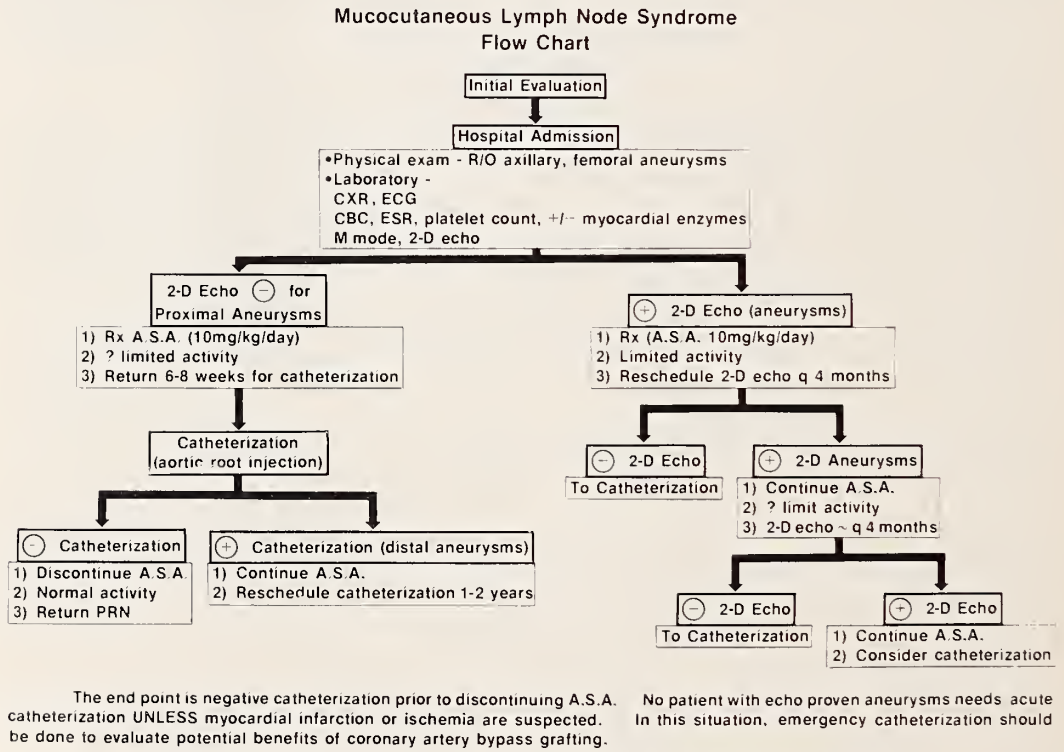


Figure 3 — Flow chart for management of patients with MCLNS.

x-ray to screen for cardiomegaly and a complete ECG to rule out arrhythmias and ischemic changes. A CBC and platelet count are also performed. If ischemia is suspected, myocardial enzymes levels are measured.

M-mode echocardiography is performed, and special note is made of left ventricular and atrial size, pericardial effusion, and indices of ventricular function. The 2-D echo is evaluated for areas of left ventricular dysynergy, pericardial effusion, and coronary artery aneurysms. If the echocardiographic studies are unremarkable

and no aneurysms are seen, the patient is treated with antiinflammatory doses of salicylates, and the dose is decreased to 10 mg/Kg/day when the ESR and signs of active inflammation subside. Catheterization is scheduled for 6-8 weeks after the initial onset of disease. If, at catheterization, there is no evidence of aneurysms, the A.S.A. is discontinued and the child is allowed to return to normal activity. If, on the other hand, the catheterization reveals previously undetected aneurysms, low dose salicylates are continued, and catheterization is rescheduled in about 1-2 years. The patient is then seen every 3 months.

If initial or follow-up 2-D echo reveals an aneurysm and there is no evidence of ischemia (right hand side of flow chart), catheterization is withheld. Though catheterization at this stage may demonstrate additional unsuspected coronary abnormalities, these data will not change management decisions in the asymptomatic child. Catheterization is performed when 2-D echo demonstrates that the aneurysms have regressed or when ischemia is suspected and surgical intervention is considered.

Early evaluation by a pediatric cardiologist is important for several reasons. Expert evaluation ensures accuracy of diagnosis, optimal management of arrhythmia in the acute and subacute phase of the disease, and careful follow-up. The latter is critical since aneurysms may develop silently in the subacute phase of the illness. Because we are unable to predict which children will develop aneurysms and we cannot make a rational decision about when to discontinue salicylates without angiographic examination, we contend that the low morbidity and mortality of an aortic root injection is acceptable and that the benefits of the procedure far outweigh potential risks.

Conclusion

Kawasaki's disease is being diagnosed frequently in the Medical College of Georgia referral area. There is a 24% incidence of coronary artery aneurysms in these patients. The life-threatening nature of these aneurysms makes it imperative that they be diagnosed and treated. In the future, improved echo or digital substraction angiography may supplant the need for aortic root injections. At this time, the only effective way to rule out peripheral coronary aneurysms is by cineangiography.

Acknowledgements

The authors wish to thank Carla Bullock and Jean Newman for secretarial assistance and Dr. Greg Janos for initially suggesting a protocol for patient management.

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Sun Damage to the Skin: Aging, Wrinkling, and Cancer

WILLIAM L. DOBES, JR., M.D., *Atlanta**

From 1977 to 1978, the National Cancer Institute conducted a survey of nonmelanoma skin cancer cases in Atlanta and seven other cities with varying intensities of solar ultra violet (UV) light. Survey results revealed that about 80% of the cases were basal cell carcinoma and that males were more at risk than females. The incidence, when age adjusted, was 281.1 per 100,000. The incidence correlated with the protective effect of skin pigment and solar indices of UV-B (290-320 NM).

Factors Related to Skin Cancer Incidence

Among the white population in the U.S., skin cancer is the most common kind of cancer. The primary cause is ultra violet radiation (UV) because:

* The cancer develops on sun exposed areas
* There is a higher incidence in outdoor workers
* The increased incidence increases as one approaches the equator
* There is a high occurrence in light-skinned people, especially those who burn easily
* There is animal model reproduction of cancer on UV exposure

Many of the survey findings confirm and document previous views about skin cancer. In Atlanta, nonmelanoma skin cancer is the most common malignant neoplasm among the white population; it exceeds that for all other forms of cancer combined. Furthermore:

* 80% were basal cells
* Males are at greater risk
* About 80% of the lesions occur on the face, head, and neck
* Skin cancer is rare among blacks, consistent with skin protective pigmentation
* The incidence is highest where UV-B exposure is high and is increasing
* A 1% increase in UV-B may lead to a 2% increase in cancer incidence
* UV-B exposure affects the increase of squamous cells more than basal cells

With the loss of the protective filter of the ozone layer in the stratosphere, we may anticipate an increase of 2% cancer incidence for every 1% increase in UV-B. We can project that approximately 400,000 to 500,000 new cases of basal and squamous cell carcinoma will develop each year in the U.S. Approximately one-fifth (80,000 to 100,000) will be squamous cell cancers with associated mortality.

* Dr. Dobes practices dermatology. Send reprints requests to him at 478 Peachtree St., NE, Atlanta, GA 30308.

Prepared at the request of the Georgia Division, American Cancer Society. Others wishing to contribute papers to this page are invited to send them to Gray T. Fountain, M.D., 910 North Jefferson, Albany, GA 31708.

The Sun's Radiation

One of the sun's radiation wave lengths, UV-C, is filtered out by the ozone layer and is quite detrimental but minimal in percent penetration. UVA and B penetrate in significant high intensity to be the most detrimental. UVB 290 to 320 is the wave length that tends to cause a burn and superficial damage; the UVA 320 to 400 nanometers (n) penetrates deeper, causing superficial but primarily more deep tissue damage, aging, and wrinkling. The combination of these two are the ones that we must therefore protect ourselves against; 400 n is visible light. If we therefore are to protect ourselves from UVA and B, the rays of light that tend to age, wrinkle, cause uneven pigmentation, pre-cancer, and skin cancer — understanding of the principles of radiation protection are necessary. This means that the radiation must be blocked before it hits the tissue it is going to hurt. There are many ways of doing this; staying out of the sun is one, or at least avoiding the sun during the intense part of the day from 10 until 3 o'clock is helpful. Utilization of protective clothing is of extreme benefit. Hats to some degree are also beneficial, but they only offer a limited degree of benefit since much of the indirect light will still hit areas such as the face. The areas that are at highest risk are the head and neck areas, the back of the hands — those areas that are chronically exposed to constant light impinging upon it.

Photo Protection — The Importance of Sunscreens

For this reason, sunscreens are extremely important and beneficial to those who need to prevent radiation damage. There are many SPF-15 sunscreens available. These are recommended by the American Academy of Pediatrics. It is best to apply sunscreens daily, especially during the summer. A good sunscreen under normal circumstances, applied once is sufficient, but under extreme conditions, athletic events, swimming — a second application may be warranted. The utilization of these highly protective sunscreens has been documented to prevent aging, wrinkling, and cancer formation. This means staying with a sunscreen of 15.

The number 15 is derived from the amount of time it takes an individual to get red in the sun, for example, ½ hour — and then when the sunscreen is applied, how many multiples of time you may stay out before getting red again; in this case, a 15 would give an individual 7½ hours of continuous sun exposure. Since there is not that much sun in a normal day, a 15 sunscreen is more than adequate; one with a higher protective factor becomes therefore an overkill.

To help educate the public, the Berger Solar Ultra Violet Meter has been used and publicized by many newspapers, radio stations, and television stations. This meter determines how much time a type III fair complexioned individual can stay in the sun before getting red. It has been used to educate the public that even a short stay in the sun can damage their skin. The fairer the skin — the higher the risk. Table 1 lists different skin types classified by their level of risk to radiation damage.

TABLE 1 — Skin Types

Skin Type	*Sensitivity to UV*	*Sunburn and Tanning History*
I	Very sensitive	Always burns easily; never tans
II	Very sensitive	Always burns easily, tans minimally
III	Sensitive	Burns moderately; tans gradually and uniformly (light brown)
IV	Moderately sensitive	Burns minimally; always tans well (moderate brown)
V	Minimally sensitive	Rarely burns, tans profusely (dark brown)
VI	Insensitive	Never burns; deeply pigmented (black)

We should continue to educate our patients about the dangers of sun exposure as well as about the risk and dangers of tanning parlors and tanning sofas. Hopefully, tans will become less attractive and pale, fair skin will again be in vogue. Those persons at high risk, living where there is a great deal of ultra violet light exposure,

should adhere closely to the warning signs that pertain to skin cancer. Urge your patients to seek treatment early for any suspicious lesion. Early detection is of critical importance in reducing significant morbidity and mortality.

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Erratum

The following table, which appeared in the Heart Page article, "Evaluation of the Cardiac Patient for Non-cardiac Surgery" on page 316 of the May *Journal,* is reprinted here with corrections underlined. We apologize for the original error.

TABLE 2 — Cardiac Risk Factors Associated with Postoperative Morbidity and Mortality

	Number of Points*
1. Myocardial infarction < 6 months prior to surgery	10
2. Age > 70 years	5
3. S-3 gallop or jugular venous distention	11
4. Significant aortic stenosis	3
5. Any rhythm other than sinus rhythm, or premature atrial contractions on last preoperative ECG	7
6. More than 5 premature ventricular contractions per minute on any previous ECG	7
7. General medical condition; any of the following: PO_2 < 60 mm Hg; PCO_2 > 50 mm Hg; K < 3.0 MEq/l; HCO_3 > 20 MEq/1; BUN > 50 mg/dl; creatinine > 3.0 mg/dl; Abnormal SGOT or signs of chronic liver disease	3
8. Emergency procedure	4
9. Intraperitoneal, thoracic, or aortic procedure	3

**Number of Points*	*Class Indicative of Cardiovascular Complication*	*% No or Minor Complications*	*% Life Threatening Complications*	*% Cardiac Death*
0-5	I	99	0.7	0.2
6-12	II	93	5	2
13-25	III	86	11	2
26	IV	22	22	56

Adapted from Goldman L et al, N Engl J Med 297,845,1977.

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CARDIZEM® (diltiazem HCl) produces an incidence of adverse reactions not greater than that reported with placebo therapy, thus contributing to the patient's sense of well-being.

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42% to 46% decrease reported in multicenter study.[1]

Increases exercise tolerance*
In Bruce exercise test,[2] control patients averaged 8.0 minutes to onset of pain; Cardizem patients averaged 9.8 minutes ($P<.005$).

*Cardizem is indicated in the treatment of angina pectoris due to coronary artery spasm and in the management of chronic stable angina (classic effort-associated angina) in patients who cannot tolerate therapy with beta-blockers and/or nitrates or who remain symptomatic despite adequate doses of these agents.

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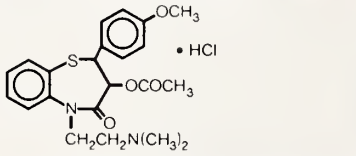
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PROFESSIONAL USE INFORMATION

cardizem®
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30 mg and 60 mg tablets

DESCRIPTION

CARDIZEM® (diltiazem hydrochloride) is a calcium ion influx inhibitor (slow channel blocker or calcium antagonist). Chemically, diltiazem hydrochloride is 1,5-Benzothiazepin-4(5H)one,3-(acetyloxy) -5-[2-(dimethylamino)ethyl]-2,3-dihydro-2-(4-methoxyphenyl)-, monohydrochloride,(+) -cis-. The chemical structure is:



Diltiazem hydrochloride is a white to off-white crystalline powder with a bitter taste. It is soluble in water, methanol, and chloroform. It has a molecular weight of 450.98. Each tablet of CARDIZEM contains either 30 mg or 60 mg diltiazem hydrochloride for oral administration.

CLINICAL PHARMACOLOGY

The therapeutic benefits achieved with CAROIZEM are believed to be related to its ability to inhibit the influx of calcium ions during membrane depolarization of cardiac and vascular smooth muscle.

Mechanisms of Action. Although precise mechanisms of its antianginal actions are still being delineated, CARDIZEM is believed to act in the following ways:

1. Angina Due to Coronary Artery Spasm: CAROIZEM has been shown to be a potent dilator of coronary arteries both epicardial and subendocardial. Spontaneous and ergonovine-induced coronary artery spasm are inhibited by CARDIZEM.
2. Exertional Angina: CARDIZEM has been shown to produce increases in exercise tolerance, probably due to its ability to reduce myocardial oxygen demand. This is accomplished via reductions in heart rate and systemic blood pressure at submaximal and maximal exercise work loads.

In animal models, diltiazem interferes with the slow inward (depolarizing) current in excitable tissue. It causes excitation-contraction uncoupling in various myocardial tissues without changes in the configuration of the action potential. Diltiazem produces relaxation of coronary vascular smooth muscle and dilation of both large and small coronary arteries at drug levels which cause little or no negative inotropic effect. The resultant increases in coronary blood flow (epicardial and subendocardial) occur in ischemic and nonischemic models and are accompanied by dose-dependent decreases in systemic blood pressure and decreases in peripheral resistance.

Hemodynamic and Electrophysiologic Effects. Like other calcium antagonists, diltiazem decreases sinoatrial and atrioventricular conduction in isolated tissues and has a negative inotropic effect in isolated preparations. In the intact animal, prolongation of the AH interval can be seen at higher doses.

In man, diltiazem prevents spontaneous and ergonovine-provoked coronary artery spasm. It causes a decrease in peripheral vascular resistance and a modest fall in blood pressure and, in exercise tolerance studies in patients with ischemic heart disease, reduces the heart rate-blood pressure product for any given work load. Studies to date, primarily in patients with good ventricular function, have not revealed evidence of a negative inotropic effect; cardiac output, ejection fraction, and left ventricular end diastolic pressure have not been affected. There are as yet few data on the interaction of diltiazem and beta-blockers. Resting heart rate is usually unchanged or slightly reduced by diltiazem.

Intravenous diltiazem in doses of 20 mg prolongs AH conduction time and AV node functional and effective refractory periods approximately 20%. In a study involving single oral doses of 300 mg of CARDIZEM in six normal volunteers, the average maximum PR prolongation was 14% with no instances of greater than first-degree AV block. Diltiazem-associated prolongation of the AH interval is not more pronounced in patients with first-degree heart block. In patients with sick sinus syndrome, diltiazem significantly prolongs sinus cycle length (up to 50% in some cases).

Chronic oral administration of CARDIZEM in doses of up to 240 mg/day has resulted in small increases in PR interval, but has not usually produced abnormal prolongation. There were, however, three instances of second-degree AV block and one instance of third-degree AV block in a group of 959 chronically treated patients.

Pharmacokinetics and Metabolism. Diltiazem is absorbed from the tablet formulation to about 80% of a reference capsule and is subject to an extensive first-pass effect, giving an absolute bioavailability (compared to intravenous dosing) of about 40%. CARDIZEM undergoes extensive hepatic metabolism in which 2% to 4% of the unchanged drug appears in the urine. In vitro binding studies show CARDIZEM is 70% to 80% bound to plasma proteins. Competitive ligand binding studies have also shown CARDIZEM binding is not altered by therapeutic concentrations of digoxin, hydrochlorothiazide, phenylbutazone, propranolol, salicylic acid, or warfarin. Single oral doses of 30 to 120 mg of CARDIZEM result in detectable plasma levels within 30 to 60 minutes and peak plasma levels two to three hours after drug administration. The plasma elimination half-life following single or multiple drug administration is approximately 3.5 hours. Desacetyl diltiazem is also present in the plasma at levels of 10% to 20% of the parent drug and is 25% to 50% as potent a coronary vasodilator as diltiazem. Therapeutic blood levels of CARDIZEM appear to be in the range of 50 to 200 ng/ml. There is a departure from dose-linearity when single doses above 60 mg are given; a 120-mg dose gave blood levels three times that of the 60-mg dose. There is no information about the effect of renal or hepatic impairment on excretion or metabolism of diltiazem.

INDICATIONS AND USAGE

1. **Angina Pectoris Due to Coronary Artery Spasm.** CARDIZEM is indicated in the treatment of angina pectoris due to coronary artery spasm. CARDIZEM has been shown effective in the treatment of spontaneous coronary artery spasm presenting as Prinzmetal's variant angina (resting angina with ST-segment elevation occurring during attacks).
2. **Chronic Stable Angina (Classic Effort-Associated Angina).** CARDIZEM is indicated in the management of chronic stable angina. CARDIZEM has been effective in controlled trials in reducing angina frequency and increasing exercise tolerance.

There are no controlled studies of the effectiveness of the concomitant use of diltiazem and beta-blockers or of the safety of this combination in patients with impaired ventricular function or conduction abnormalities.

CONTRAINDICATIONS

CAROIZEM is contraindicated in (1) patients with sick sinus syndrome except in the presence of a functioning ventricular pacemaker, (2) patients with second- or third-degree AV block except in the presence of a functioning ventricular pacemaker, and (3) patients with hypotension (less than 90 mm Hg systolic).

WARNINGS

1. **Cardiac Conduction.** CARDIZEM prolongs AV node refractory periods without significantly prolonging sinus node recovery time, except in patients with sick sinus syndrome. This effect may rarely result in abnormally slow heart rates (particularly in patients with sick sinus syndrome) or second- or third-degree AV block (six of 1243 patients for 0.48%). Concomitant use of diltiazem with beta-blockers or digitalis may result in additive effects on cardiac conduction. A patient with Prinzmetal's angina developed periods of asystole (2 to 5 seconds) after a single dose of 60 mg of diltiazem.
2. **Congestive Heart Failure.** Although diltiazem has a negative inotropic effect in isolated animal tissue preparations, hemodynamic studies in humans with normal ventricular function have not shown a reduction in cardiac index nor consistent negative effects on contractility (dp/dt). Experience with the use of CARDIZEM alone or in combination with beta-blockers in patients with impaired ventricular function is very limited. Caution should be exercised when using the drug in such patients.
3. **Hypotension.** Decreases in blood pressure associated with CAROIZEM therapy may occasionally result in symptomatic hypotension.
4. **Acute Hepatic Injury.** In rare instances, patients receiving CAROIZEM have exhibited reversible acute hepatic injury as evidenced by moderate to extreme elevations of liver enzymes. (See PRECAUTIONS and ADVERSE REACTIONS.)

PRECAUTIONS

General. CAROIZEM (diltiazem hydrochloride) is extensively metabolized by the liver and excreted by the kidneys and in bile. As with any new drug given over prolonged periods, laboratory parameters should be monitored at regular intervals. The drug should be used with caution in patients with impaired renal or hepatic function. In subacute and chronic dog and rat studies designed to produce toxicity, high doses of diltiazem were associated with hepatic damage. In special subacute hepatic studies, oral doses of 125 mg/kg and higher in rats were associated with histological changes in the liver which were reversible when the drug was discontinued. In dogs, doses of 20 mg/kg were also associated with hepatic changes; however, these changes were reversible with continued dosing.

Drug Interaction. Pharmacologic studies indicate that there may be additive effects in prolonging AV conduction when using beta-blockers or digitalis concomitantly with CARDIZEM. (See WARNINGS).

Controlled and uncontrolled domestic studies suggest that concomitant use of CARDIZEM and beta-blockers or digitalis is usually well tolerated. Available data are not sufficient, however, to predict the effects of concomitant treatment, particularly in patients with left ventricular dysfunction or cardiac conduction abnormalities. In healthy volunteers, diltiazem has been shown to increase serum digoxin levels up to 20%.

Carcinogenesis, Mutagenesis, Impairment of Fertility. A 24-month study in rats and a 21-month study in mice showed no evidence of carcinogenicity. There was also no mutagenic response in in vitro bacterial tests. No intrinsic effect on fertility was observed in rats.

Pregnancy. Category C. Reproduction studies have been conducted in mice, rats, and rabbits. Administration of doses ranging from five to ten times greater (on a mg/kg basis) than the daily recommended therapeutic dose has resulted in embryo and fetal lethality. These doses, in some studies, have been reported to cause skeletal abnormalities. In the perinatal/postnatal studies, there was some reduction in early individual pup weights and survival rates. There was an increased incidence of stillbirths at doses of 20 times the human dose or greater.

There are no well-controlled studies in pregnant women; therefore, use CARDIZEM in pregnant women only if the potential benefit justifies the potential risk to the fetus.

Nursing Mothers. It is not known whether this drug is excreted in human milk. Because many drugs are excreted in human milk, exercise caution when CARDIZEM is administered to a nursing woman if the drug's benefits are thought to outweigh its potential risks in this situation.

Pediatric Use. Safety and effectiveness in children have not been established.

ADVERSE REACTIONS

Serious adverse reactions have been rare in studies carried out to date, but it should be recognized that patients with impaired ventricular function and cardiac conduction abnormalities have usually been excluded.

In domestic placebo-controlled trials, the incidence of adverse reactions reported during CARDIZEM therapy was not greater than that reported during placebo therapy.

The following represent occurrences observed in clinical studies which can be at least reasonably associated with the pharmacology of calcium influx inhibition. In many cases, the relationship to CARDIZEM has not been established. The most common occurrences, as well as their frequency of presentation, are: edema (2.4%), headache (2.1%), nausea (1.9%), dizziness (1.5%), rash (1.3%), asthenia (1.2%), AV block (1.1%). In addition, the following events were reported infrequently (less than 1%) with the order of presentation corresponding to the relative frequency of occurrence.

Cardiovascular:	Flushing, arrhythmia, hypotension, bradycardia, palpitations, congestive heart failure, syncope.
Nervous System:	Paresthesia, nervousness, somnolence, tremor, insomnia, hallucinations, and amnesia.
Gastrointestinal:	Constipation, dyspepsia, diarrhea, vomiting, mild elevations of alkaline phosphatase, SGOT, SGPT, and LDH.
Dermatologic:	Pruritus, petechiae, urticaria, photosensitivity.
Other:	Polyuria, nocturia.

The following additional experiences have been noted:

A patient with Prinzmetal's angina experiencing episodes of vasospastic angina developed periods of transient asymptomatic asystole approximately five hours after receiving a single 60-mg dose of CAROIZEM.

The following postmarketing events have been reported infrequently in patients receiving CAROIZEM: erythema multiforme; leukopenia; and extreme elevations of alkaline phosphatase, SGOT, SGPT, LOH, and CPK. However, a definitive cause and effect between these events and CAROIZEM therapy is yet to be established.

OVERDOSAGE OR EXAGGERATED RESPONSE

Overdosage experience with oral diltiazem has been limited. Single oral doses of 300 mg of CARDIZEM have been well tolerated by healthy volunteers. In the event of overdosage or exaggerated response, appropriate supportive measures should be employed in addition to gastric lavage. The following measures may be considered:

Bradycardia	Administer atropine (0.60 to 1.0 mg). If there is no response to vagal blockade, administer isoproterenol cautiously.
High-Degree AV Block	Treat as for bradycardia above. Fixed high-degree AV block should be treated with cardiac pacing.
Cardiac Failure	Administer inotropic agents (isoproterenol, dopamine, or dobutamine) and diuretics.
Hypotension	Vasopressors (eg, dopamine or levarterenol bitartrate).

Actual treatment and dosage should depend on the severity of the clinical situation and the judgment and experience of the treating physician.

The oral LD_{50}'s in mice and rats range from 415 to 740 mg/kg and from 560 to 810 mg/kg, respectively. The intravenous LO_{50}'s in these species were 60 and 38 mg/kg, respectively. The oral LD_{50} in dogs is considered to be in excess of 50 mg/kg, while lethality was seen in monkeys at 360 mg/kg. The toxic dose in man is not known, but blood levels in excess of 800 ng/ml have not been associated with toxicity.

DOSAGE AND ADMINISTRATION

Exertional Angina Pectoris Due to Atherosclerotic Coronary Artery Disease or Angina Pectoris at Rest Due to Coronary Artery Spasm. Dosage must be adjusted to each patient's needs. Starting with 30 mg four times daily, before meals and at bedtime, dosage should be increased gradually (given in divided doses three or four times daily) at one- to two-day intervals until optimum response is obtained. Although individual patients may respond to any dosage level, the average optimum dosage range appears to be 180 to 240 mg/day. There are no available data concerning dosage requirements in patients with impaired renal or hepatic function. If the drug must be used in such patients, titration should be carried out with particular caution.

Concomitant Use With Other Antianginal Agents:

1. **Sublingual NTG** may be taken as required to abort acute anginal attacks during CAROIZEM therapy.
2. **Prophylactic Nitrate Therapy** — CARDIZEM may be safely coadministered with short- and long-acting nitrates, but there have been no controlled studies to evaluate the antianginal effectiveness of this combination.
3. **Beta-blockers.** (See WARNINGS and PRECAUTIONS.)

HOW SUPPLIED

Cardizem 30-mg tablets are supplied in bottles of 100 (NOC 0088-1771-47) and in Unit Dose Identification Paks of 100 (NOC 0088-1771-49). Each green tablet is engraved with MARION on one side and 1771 engraved on the other. CARDIZEM 60-mg scored tablets are supplied in bottles of 100 (NOC 0088-1772-47) and in Unit Dose Identification Paks of 100 (NOC 0088-1772-49). Each yellow tablet is engraved with MARION on one side and 1772 on the other.

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president's letter



They Are Our Future

FUTURE LEADERS of our profession are now in medical school or residency programs across our state and nation. These young professionals will practice in our towns and cities, will do research and teach in our institutions, and will be responsible for leading the Medical Association of Georgia as it faces the future.

The Resident and Medical Student Sections at the AMA have impressed everyone with their well reasoned input into that organization. And membership in these sections is growing more rapidly than any other part of the AMA. Acceptance of them was not automatic but has been earned over the years.

These young doctors have a good grasp of what is going on, and they are vitally concerned about their future in medicine. They are filled with youthful idealism but are not part of the counter culture or rebellious youth of the past decade. They have their feet on the ground.

The respect of the AMA House of Delegates for our young colleagues was reflected in the creation of a voting position for a Resident on the AMA Board of Trustees and a non-voting position for a Medical Student.

Closer home, in 1983, our MAG House of Delegates amended our Constitution and Bylaws to allow the organization of a Resident Section with a voting delegate from this section to the MAG House. This year it provided for the establishment of the Medical Student Section, with a non-voting delegate to the MAG House. The Resident Section has not been organized, but hopefully this year we will provide whatever staff leadership and support is necessary so that both groups in Georgia can become actively involved in our affairs.

It is a known fact that Residents and Medical Students who join the AMA (they are allowed to do so by direct membership in the AMA) while in training continue as active AMA members after they finish their training in a far higher percentage than those who wait until after training to join. This also should be true with students and residents in Georgia and their continued membership in the MAG.

Our own Harrison L. "Jack" Rogers, President-Elect of the AMA, has announced that his major thrust during the next 3 years as President-Elect, President, and Past President will be to increase membership in the AMA. We will give strong support to this effort in Georgia as well as working to increase membership in the MAG. Only 5600 of the 8000 doctors in Georgia belong to the MAG, so our work is cut out for us. Expanding MAG membership into the established medical community will require an ongoing recruitment program — peer to peer.

Those in residency programs and medical schools are an untapped resource in Georgia. We need to get them involved as members to avail ourselves of their bright young minds and energies.

THEY ARE OUR FUTURE!

S. William Clark

S. William Clark, Jr., M.D.

Postscript to residents and medical students: If you do not receive adequate leadership and support from the MAG toward organizing your sections this year, please ask me "Why not?"

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Amster, Steven M., Wayne—ACT—AN
Wayne Memorial Hospital, Box 408, Jesup, 31545

Anderson, James D., D.D.S., MAA—Affiliate
6075 Roswell Rd., NE, Ste. 535, Atlanta 30328

Aranda, Ricardo J., Floyd-Polk-Chattooga—ACT—OBG
320 W. Ninth St., Rome 30161

Banderas, Julio C., Clayton-Fayette—ACT—ORS
113 Upper Riverdale Rd., Riverdale 30274

Bergman, Bernard A., MAA—ACT—CHP/P
3280 Howell Mill Rd., Ste. 230, Atlanta 30327

Bobrakov, Erem E., MAA—ACT (N-2)—FP
573 W. Peachtree St., Ste. 415, Atlanta 30308

Bookout, Mark W., Whitfield-Murray—ACT (N-2)—OTO
1436 Broadrick Dr., Dalton 30720

Boudet, Ononiel M., Baldwin—ACT—GP
Central State Hospital, Boone Bldg., Milledgeville 31062

Burns, Robert A., Whitfield-Murray—ACT (N-2)—GS
1109 Burleyson Dr., Dalton 30720

Byers, Kenneth W., Gordon—ACT—IM
2 Hospital Ct., Calhoun 30701

Carter, Richard F., Troup—ACT—IM/GE
Clark Holder Clinic, LaGrange 30240

Carter, Stephen L., DeKalb—ACT (N-2)
7660 Covington Hwy., Lithonia 30058

Clary, William A., Georgia Medical—ACT (N-2)—N
4 Jackson Blvd., Savannah 31409

Cuttone, James M., Newton-Rockdale—ACT—OPH
1309 Milstead Rd., Conyers 30207

Darden, William A., Jr., Georgia Medical—ACT (N-2)—GS
200 E. 31st St., Savannah 31499

Davis, Lawton C., Laurens—ACT (N-2)—IM
606 Academy Ave., Dublin 31021

Ezekwuche, Christian M., Bibb—ACT—OBG
770 Pine St., Ste. 310, Macon 31201

Faucher, Marie, Newton-Rockdale—ACT (N-1)—AN
3306 Hidden Forest Dr., Snellville 30278

Floyd, Joseph B., Gwinnett-Forsyth—ACT (N-2)—AN
2121-B Fountain Dr., Snellville 30278

Fortson, Mark R., Muscogee—ACT (N-2)—IM
1005 Talbotton Rd., Columbus 31995

Gambrell, R. Don, Jr., Richmond—ACT—OBG/END
903 Fifteenth St., Augusta 30901

Gay, Gregory L., Richmond—ACT (N-2)—AN
Dept. of Anesthesiology, Medical College of Georgia, Augusta 30912

Gollobin, Glenn S., DeKalb—I&R
1075-B N. Jamestown Rd., Decatur 30033

Grubbs, John E., Floyd-Polk-Chattooga—ACT—N
1825 Martha Berry Blvd., Rome 30161

Gunn, Joseph B., Hall—ACT (N-2)—PD
247 S. Enota Dr., Gainesville 30505

Hagler, Abigail, MAA—I&R—IM
69 Butler St., Atlanta 30303

Hasan, Khalil A., Bibb—ACT (N-2)—GS
3854 Riverside Dr., Macon 31210

Hays, William A., Crawford W. Long—ACT—P/CHP
440 College Ave., Ste. 110, Athens 30603

Houston, Thomas P., Floyd-Polk-Chattooga—ACT—FP
302 Turner McCall Blvd., Rome 30161

Howell, Douglas E., Clayton-Fayette—ACT—GS
33 SW Upper Riverdale Rd., Ste. 125, Riverdale 30274

Hunt, Loren W., Crawford W. Long—ACT—IM/PUD
1010 Prince Ave., Athens 30606

Jackson, Thomas W., Floyd-Polk-Chattooga—ACT—OBG
320 W. Ninth St., Rome 30161

Johnson, George C., Hall—ACT (N-2)—P
660-C Lanier Park Dr., Gainesville 30505

Johnston, Jack H., Cobb—ACT—IM
86 S. Cobb Dr., Dept. of Medicine, Marietta 30060

Karpas, Anthony E., MAA—ACT (N-2)—END
478 Peachtree St., NE, Atlanta 30308

Levine, Keith A., DeKalb—ACT (N-1)
2121 Fountain Dr., Ste. 301, Snellville 30278

Lowrey Darrell G., Floyd-Polk-Chattooga—ACT (N-2)—ORS
1825 Martha Berry Blvd., Rome 30161

Lucas, Stephen K., Crawford W. Long—ACT (N-2)—IM
1010 Prince Ave., Ste. 112, Athens 30606

Magat, Wilfrido M., Gwinnett-Forsyth—ACT—AN
2121-B Fountain Dr., Snellville 30278

Mallory, James D., Jr., MAA—ACT—P
4350 Georgetown Sq., Ste. 714, Atlanta 30338

Maxey, Joy A., Richmond—I&R
307 Greene St., Augusta 30901

Meadows, James A., III, Georgia Medical—ACT—IM/TS
11706 Mercy Blvd., #6, Savannah 31406

Mirsky, Robert S., MAA—ACT (N-2)—IM
4484 N. Shallowford Rd., Atlanta 30338

Oliver, John H., Richmond—ACT—OBG
1501 Anthony Rd., Augusta 30910

Plauché, Wade E., Troup—ACT—R
210 Battle St., LaGrange 30240

Richmond, John D., Whitfield-Murray—ACT—IM/NEP
1406 Broadrick Dr., Dalton 30720

Rogers, John J., Bibb—ACT (N-2)—GS
770 Pine St., Ste. 220, Macon 31201

Ross, Jack R., Muscogee—I&R—FP
The Medical Center, Columbus 31994

Sans, Diego C., Baldwin—ACT—P
Powell 2 East, Central State Hospital, Milledgeville 31062

Schnapper, Robert A., MAA—ACT—N/IM
315 Boulevard, NE, Ste. 224, Atlanta 30312

Schnell, Frederick M., Bibb—ACT—HEM/ON
729 Pine St., Macon 31201

Serra, Marian H., MAA—I&R—EM
80 Butler St., Atlanta 30303

Stewart, Betty G., South Georgia—ACT—P/N
P. O. Box 1804, Valdosta 31601

Talley, Joel D., III, DeKalb—I&R—IM
1750-13 Clairmont Rd., Decatur 30033

Tan, Carlos Y., Georgia Medical—ACT—GS/GP
4 Pooler Professional Plaza, Pooler 31322

Vasquez, Joseph G., Southwest Georgia—ACT—FP/EM
315 Columbia Rd., P. O. Box 429, Blakely 31723

Walker, Gary K., Bibb—ACT (N-2)—PTH
Medical Center of Central Georgia, box 6000-20, Macon 31208

Ward, Bradley L., Floyd-Polk-Chattooga—ACT (N2)—FP
P. O. Box 139, Taylorsville 30178

Ward, Norman S., Cherokee-Pickens—ACT (N-2)—FP
385 South Ave., Rochester, NY 14620

Watt, James A., Glynn—ACT—P/PTH
P. O. Drawer 1291, Darien 31305

Weeks, Wallace R., Whitfield-Murray—ACT (N-2)—FP
1012 Burleyson Dr., Dalton 31720

Weidenheim, Karen M., DeKalb—I&R
Emory University Pathology & Lab, Atlanta 30322

Weinstein, Michael N., MAA—ACT (N-2)—GE/IM
8740 Roswell Rd., NE, Apt. 5-H, Atlanta 30338

Wright, Malcolm G., Glynn—I&R—IM
520 Ocean Blvd., Ste. 115, St. Simons Island 31522

Young, Marion M., Walker-Catoosa-Dade—Retired—P/PM
LaFayette Mental Health Center, LaFayette 30728

PERSONALS

First District

Ruben D. Silan, M.D., of Hinesville, was installed as President of the Philippine American Medical Association of Georgia (PAMAG) on Saturday, June 16, during the 15th general business meeting in Orlando, Florida.

Third District

Columbus surgeon, **Maurice Delmar Edwards, M.D.,** was inducted as an alumni member to the Arkansas Alpha Chapter of Alpha Omega Alpha (AOA), at a banquet held March 16, in Little Rock, Arkansas. The purpose of AOA, which is the only national medical honor society in the world, is to recognize and perpetuate excellence in the medical profession.

Dr. Edwards is assistant clinical professor of surgery on the Medical College of Georgia staff in Columbus. He has twice been elected chairman of The Medical Center Department of Surgery and is today chief of general surgery at the hospital. For nearly a decade, Dr. Edwards has been chairman of the St. Francis surgery credentials committee. His contributions to his community, his profession, and his patients have been of inestimable value.

Fifth District

E. Garland Herndon, Jr., M.D., Senior Vice President of Emory University, and **Eugene H. Hirsh, M.D.,** Atlanta internist, were elected to Fellowship of the American College of Physicians.

East Point surgeon, **Thomas Robert Nolan, M.D.,** has been selected as the Medical Director of South Fulton Hospital. He is the first fulltime Medical Director for the hospital.

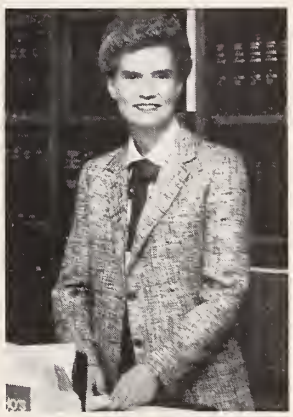
Atlanta psychiatrist, **Ronald C. Bloodworth, M.D.,** has been named medical director for the Psychiatric Institute of Atlanta (PIA). He began working at PIA in 1980 and most recently was clinical director. He is a pioneer in



Representative Bobby E. Parham, of Milledgeville, was presented with MAG's Certificate of Appreciation at the recent House of Delegates in Atlanta by William Headley, M.D., also of Milledgeville. He was one of three Georgia legislators to receive this award.

the field of pharmacology and started Georgia's first neuropsychiatric evaluation program. Dr. Bloodworth received his medical degree from MCG and completed his residency at Emory.

Bernard S. Lipman, M.D., Atlanta cardiologist, has co-authored 7th Edition, *Clinical Electrocardiography* which was recently published by Year Book Medical Publishers. The book is a reference for all those involved in electrocardiography.



Luella Klein, M.D.

Luella Klein, M.D., of Atlanta, has become president of The American College of Obstetricians and Gynecologists (ACOG), for 1984-85, at the College's 32nd Annual Clinical Meeting in San Francisco. She is the first woman to become president of the organization.

A private practitioner at Emory University Clinic, Dr. Klein is deputy chief of the obstetric service at Grady Memorial Hospital and professor of OB/GYN at Emory University School of Medicine. She is co-director of the Regional Perinatal Center of Atlanta. Dr. Klein is a board-certified subspecialist in maternal-fetal medicine.

At Grady Memorial Hospital, Dr. Klein is director of both the High Risk Maternal and Infant Care Project and the Teen Services Clinic. She was a prominent member of ACOG's Task Force on Adolescent Pregnancy (1979-81) and is ACOG's representative to the American Academy of Pediatrics' Committee on Adolescence (1979-present). She was vice president of the College from 1982 to 1983 and a member of the Task Force for the Advancement of Women in Obstetrics and Gynecology (1981-82).

Dr. Klein is currently an examiner for the American Board of Obstetrics and Gynecology and chairman of the Maternal and Infant Health Committee of the MAG.

Sixth District

Garnett J. Giesler, M.D., has been voted president-elect of the Georgia Thoracic Society. Specializing in pulmonology, Dr. Giesler practices at the Clark-Holder Clinic in LaGrange.

Family practitioner, **Ferrol A. Sams, Jr., M.D.,** of Fayetteville, was recently honored by the Emory University Alumni Association with the Award of Honor for Distinguished Achievement in the Arts and Profession. Dr. Sams is the author of the novel, *Run With The Horseman.*

Seventh District

John D. Richmond, M.D., of Dalton, was elected to Fellowship of the American College of Physicians.

The Carroll County Board of Health has named **C. Edward Stevenson, Jr., M.D.,** of Carrollton, as the consulting pediatrician for the Health Department. Dr. Stevenson received his medical training from Emory University School of Medicine.

Eighth District

Richard Smith, Jr., M.D., will begin his practice in Internal Medicine and Family Practice in Cochran after completing his residency at the Georgia Baptist Hospital in Atlanta in July. He graduated from MCG in 1979.

Ninth District

North Fulton Medical Center has announced the appointment of **Jerome Silver, M.D.,** as hospital director of radiology. Dr. Silver moved his practice from Lanier Park Hospital in Gainesville.

Tenth District

Shiraz H. Kassam, M.D., Conyers obstetrician and gynecologist has recently had three of his clinical case studies published. Dr. Kassam is a clinical assistant professor in the Department of Obstetrics and Gynecology at the Medical College of Georgia in Augusta and wrote articles which appeared in *The Journal of Reproductive Medicine* and *The Female Patient.*

Frances Joseph Tedesco, M.D., a gastroenterologist from Augusta, was elected president of the American Society for Gastrointestinal Endoscopy (ASCGE) at the group's annual meeting in New Orleans.

DEATHS

William C. T. Jernigan

William C. T. Jernigan, M.D., of Columbus, died May 23 of lung cancer at the age of 48. His illness was diagnosed only one week before his death. Dr. Jernigan was a graduate of the University of Miami School of Medicine. He was a certified Diplomate with the American Board of Family Practice. He was president of the Muscogee County Medical Society in 1983, a member of The Medical Center Hospital Authority board of trustees, immediate past chief of staff at Doctors Hospital and a staff member at all three Columbus hospitals.

Dr. Jernigan is survived by his wife, his mother, one son, one daughter, and two brothers.

James Park Hanner

James Park Hanner, M.D., former president of the Henrietta Egleston Hospital for Children medical staff, died April 11 after a short illness. He was 79. Dr. Hanner graduated from Emory University and Johns Hopkins University Medical School. He was also on the staff at Piedmont, Crawford W. Long Memorial, Northside, and DeKalb General hospitals. Dr. Hanner was former president of the Georgia Pediatric Society and a member of the American Academy of Pediatrics.

Survivors include his wife, one son, one daughter, and one sister.

Marion Albon Hubert

Marion Albon Hubert, M.D., aged 84, University of Georgia Team Physician from 1936 to 1983, died May 21 after an extended illness. Dr. Hubert was a graduate of Emory University School of Medicine. He later continued postgraduate work at the Mayo Clinic and Johns Hopkins Hospital. During World War II, he served with the U.S. Army Medical Corps for 3½ years. He was on the Board of Directors of Blue Cross/Blue Shield of Columbus and was an honorary member of the National Athletic Trainers Association. In 1973, Dr. Hubert was issued a citation by the Georgia Sports Hall of Fame for his service to sports.

Survivors include his wife, two daughters, and four grandchildren.

Walter P. Rhyne

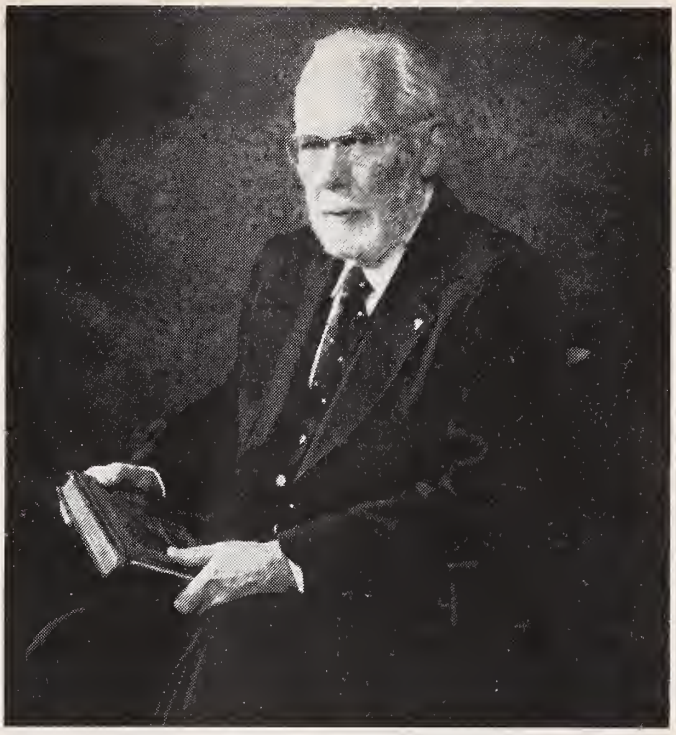
Walter P. Rhyne, M.D., of Albany, died April 2 at age 80. A native of Jasper, Dr. Rhyne was a graduate of the Medical College of Georgia. He was a life member of the Southern Medical Association, the American Academy of Ophthalmology, The Georgia Society of Ophthalmology, the Association of Railway Surgeons, the Aerospace Medical Association and the Fifty-Year Club of American Medicine.

A 32nd Degree Scottish Rite Mason, Dr. Rhyne was a member of the Albany Kiwanis Club, the Albany Chamber of Commerce, the Albany Community Concert Association, the Southwest Georgia Sportsman's Club and Ducks Unlimited, to name just a few of his community affiliations. A retired Air Force Reserve colonel, he was also a member of the Reserve Officers Association of the United States, the Retired Officers Association, and the Air Force Association.

Dr. Rhyne is survived by his wife, one son, one daughter, three sisters, and two grandchildren.

Thomas A. Sappington

Thomas A. Sappington, M.D., former president of the Georgia Academy of Family Physicians, died May 31 at the age of 71. Dr. Sappington headed the Georgia Academy of Family Physicians in 1970 and was named Family Physician of the Year in 1971. A native of Turner County near Sycamore, he graduated from Vanderbilt University School of Medicine. He was former medical officer of the Upson County Health Department and Upson County medical examiner. Dr. Sappington was instrumental in establishing the Department of Family Practice at the Medical College of Georgia. A library of family medical practice is named there in his honor. Dr. Sappington also belonged to Morning Star Masonic Lodge No. 27.



Dr. Thomas Asbury Sappington

Survivors include his wife, one son, and two daughters.

R. Hugh Wood

R. Hugh Wood, M.D., former dean of Emory University School of Medicine, died May 22 at the age of 87. He was a pioneer in the development of Emory University School of Medicine. As dean from 1946-56, he guided its transition from dependence upon volunteer practitioners to the use of fulltime clinical doctors as chiefs of the various services. Dr. Wood became the first director of the Emory Clinic in 1953 and held dual roles of clinic director and medical dean until 1956, when he retired as dean to direct the clinic fulltime. He was one of three physicans appointed by then-Gov. Ernest Vandiver in 1959 to study conditions at the State Hospital for the mentally ill at Milledgeville.

Dr. Wood made the first known diagnosis of sickle cell anemia in Georgia. He published numerous articles on hypertension and psychosomatic medicine. He received honorary degrees from the Medical College of Virginia and Hampden-Sydney College. He was given the Algernon Sydney Sullivan Medallion, an academic and humanitarian award. He was the first physician in the South to receive the Gold Headed Cane, a British emblem of excellence. He was president of the Fulton County Medical Society in 1946-47 and a fellow of the American College of Physicians.

Survivors include his wife, one brother, and two sisters.

Physician's Recognition Award Recipients

LISTED BELOW *are those physicians in Georgia who have earned the AMA's Physician's Recognition Award (PRA) from January through March, 1984.*

The Award was established in 1969 "to recognize, encourage, and support physicians who participate regularly in continuing medical education and to emphasize the importance of developing more meaningful continuing medical education opportunities for physicians." A minimum of 150 credit hours of CME must be earned over a 3-year period to qualify for the Award. The hours may include such activities as conferences, residencies, teaching, writing, private reading, listening to cassettes, home study courses, consultation, and peer review; at least 60 of the hours, however, must be from formal CME programs sponsored or co-sponsored for Category I credit by organizations accredited for these activities.

The MAG House of Delegates has set a goal that all MAG members shall have received the PRA by 1985. We congratulate the following physicians who have distinguished themselves and their profession by their commitment to continuing education:

Alfred Agrin, Gainesville
Albert A. Albatrosov, Savannah
Henry Alperin, Augusta
Manuel L. Alvarez, Savannah
Ramon Vicente Alvarez, St. Marys
William J. Atha, Rome
Paul C. Atwater, Atlanta
Ezzat M. Aziz, Augusta
Charles E. Bagley, Alma
Jackson H. Bates, Marietta
Merion M. Beckwith, Augusta
Arnold J. Berry, Atlanta
Judson G. Black, Atlanta
Belford C. Blaine, Atlanta
Howard S. Brown, Atlanta
Nyda W. Brown, Smyrna
James R. Burns, Gainesville
David E. Burtner, Macon
Dwight D. Campbell, Savannah
F. J. Cardenas-Molina, Lithia Springs
James M. Carson, Atlanta
Moo H. Cho, Columbus
David L. Cooper, Riverdale
George K. Covert, Stone Mountain
James H. Crowdis, Blakely
Hoyt W. Crump, Royston
Ernest F. Daniel, Augusta
Harry N. Davis, Canton
Benjamin B. De Gracia, Atlanta
Abelardo R. Delgado, Milledgeville
Richard E. DuBois, Atlanta
Charles A. Duggan, Macon
Ibrahim N. Elsahy, Riverdale
Edwin C. Evans, Atlanta
Stuart M. Finch, Augusta
David G. Fisher, Atlanta
Edwin E. Flournoy, Albany
Henry A. Foster, Griffin
Larry D. Gattis, Hawkinsville
Arthur Gelbart, Augusta
John T. Godwin, Atlanta
Sara L. Goolsby, Rossville
Woodrow Goss, Ashburn
Warren L. Griffin, Macon
Patrick A. Griffith, Atlanta
Jerold A. Haber, Atlanta
Joseph E. Hall, Augusta
Frank Hardeman, Savannah
Henry W. Harris, Columbus
Sanford S. Hartman, Decatur
George S. Heath, Waycross
Douglas P. Hein, Jesup
Charles A. Henderson, Atlanta
Hugh O. Hodges, Winder
Thomas L. Hodges, Clarkesville
Warren B. Horn, Athens
John C. House, Winder
Jack R. Hunt, Columbus
Clarence Joe, Augusta
Randy L. Judd, Atlanta
Douglas K. Kehl, Atlanta
Pil K. Kim, Riverdale
Tae-Hyung Kim, Atlanta
Thomas K. Kobayashi, Clarkeston
Carl E. Lane, Macon
Charles A. Lanford, Macon
Fred A. Levin, Conyers
David P. Lyle, Martinez
Mahmud Majanovic, Milledgeville
Alfonso, Marmolejo, Atlanta
Stephen C. May, Kennesaw
Barton A. McCrum, Gainesville
William L. McDaniel, Dalton
Earl T. McGhee, Dalton
Marilynne McKay, Decatur
Walter V. Meadors, Warner Robins
Peter L. Meehan, Atlanta
Charles A. Meyer, Augusta
James W. Mimbs, Milledgeville
Stephen Morgan, Riverdale
Harvey V. Morgan, Savannah
Robert N. Murdock, Columbus
Joseph B. Namer, Smyrna
Fenwick T. Nichols, Savannah
W. Lanier Nicholson, Hiawassee
John B. O'Neal, Elberton
Juneseok Park, Sylvester
E. Mansell Pattison, Augusta
Claude L. Pennington, Macon
Edwin N. Preston, Norcross
Stephen N. Rando, Macon
Asbury C. Robinson, Douglasville
Reza Sabet, LaGrange
Armando C. Santiago, Lyons
Zoumeir A. Shama, Chamblee
Howel W. Slaughter, Atlanta
Robert L. Smith, Augusta
W. T. Smith, Milledgeville
Alfredo E. Suarez, Baxley
Joseph R. Swartwout, Macon
Marvin D. Tark, Marietta
William K. Thomas, Atlanta
John J. Vecchio, Warner Robins
Christopher J. Walker, Gainesville
Robert D. Waller, Albany
Jerry O. Weaver, Cedartown
Stewart E. Wiegand, Atlanta
R. Mark Wilkiemeyer, Atlanta
Caroline J. Williams, Savannah
Howard S. Yager, Atlanta
Linda Li-Chao Yang, Savannah
Raymond A. Young, Rome
William D. Zeichner, Alpharetta
Vincent N. Zubowicz, Atlanta

Classifieds . . .

PHYSICIAN WANTED

Physicians interested in practice opportunities in the Southeast, please contact: Director, Physician Recruitment, Regional Health Service, Inc., P. O. Box 2345, Anniston, AL 36202 (205) 236-2907.

Psychiatrist: Georgia-St. Simons Island — General psychiatrist with inpatient experience to work with expanding group practice. High starting salary. Resort area with growing population. New 60-bed hospital. Reply to Box 4-B c/o *Journal*.

Retired or semi-retired family practice or internist to help with week-day and weekend work in my office and in the hospital. Send CV to: Occupant, 8115 S.W. 1st Place, Gainesville, FL 32605.

OB/GYN — Immediate opening for board eligible or certified as an associate in a well established practice. Excellent starting salary; malpractice insurance provided. Two offices, one in Tennessee and one in Georgia. Five major hospitals in the area. Respond to: F. Jones Smiley, MD, 931 Spring Creek Rd., Ste. 107, Chattanooga, TN 37412.

Emergency Medicine — Excellent full-time and part-time positions available in the Atlanta area and coastal Georgia. Directorships also available. Low to moderate volume facilities. Competitive income and benefits package provided. For more detailed information, please contact Katie Sherrill, Spectrum Emergency Care, Inc., 1111 N. Westshore Blvd., Suite 211, Tampa, FL 33607 or call collect (813) 870-2356.

Anesthesiologist — Excellent opportunity for BC/BE Anesthesiologist in rural piedmont South Carolina. Located between two metropolitan areas within 45 minutes driving time; 3 hours to beaches or mountains. JCAH accredited 119-bed hospital newly renovated with well trained staff. Three full-time CRNAs. Young, aggressive medical staff. Send CV to Ron Hunter, Administrator, Chester County Hospital, Chester, SC 29706 or call (803) 377-3151.

Orthopedic Surgeon — Rural Piedmont South Carolina community offers excellent opportunity for BC/BE Orthopedic Surgeon. Share call with one other orthopedist. Community located between two metropolitan areas within 45 minutes driving time; 3 hours to beaches or mountains. JCAH accredited 119-bed hospital newly renovated with well trained staff. Young, aggressive medical staff. Send CV to Ron Hunter, Administrator, Chester County Hospital, Chester, SC 29706 (803) 377-3151.

Orthopedic Surgeon — needed in Middle Tennessee, to be affiliated with a 100+ bed hospital with intensive care unit and emergency room. Limited coverage can be provided. Must be Board eligible or certified. Attractive financial package including guaranteed minimum collections, assistance with office rent and expense, moving and interview expenses paid. Wide range of recreational activities available in the immediate area. Reply to Box 7-A c/o *Journal*.

OB/GYN — needed in Middle Tennessee to be affiliated with a 100+ bed hospital with intensive care unit and emergency room, limited coverage can be provided. Must be Board eligible or certified. Attractive financial package including guaranteed minimum collections, assistance with office rent and expense, moving and interview expenses paid. Wide range of recreational activities available in the immediate area. Reply to Box 7-A c/o *Journal*.

SITUATION WANTED

General and Vascular Surgeon — Board certified in surgery wishes to relocate in or near Atlanta. Other locations considered. Will consider any practice arrangements. Reply to Box 7-B c/o *Journal*.

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> Soter NA, Wasserman SI, Austen KF. Cold urticaria release into circulation of histamine and eosinophil chemotactic factor of anaphylaxis during cold challenge. N Engl J Med 1976;294:687-90.

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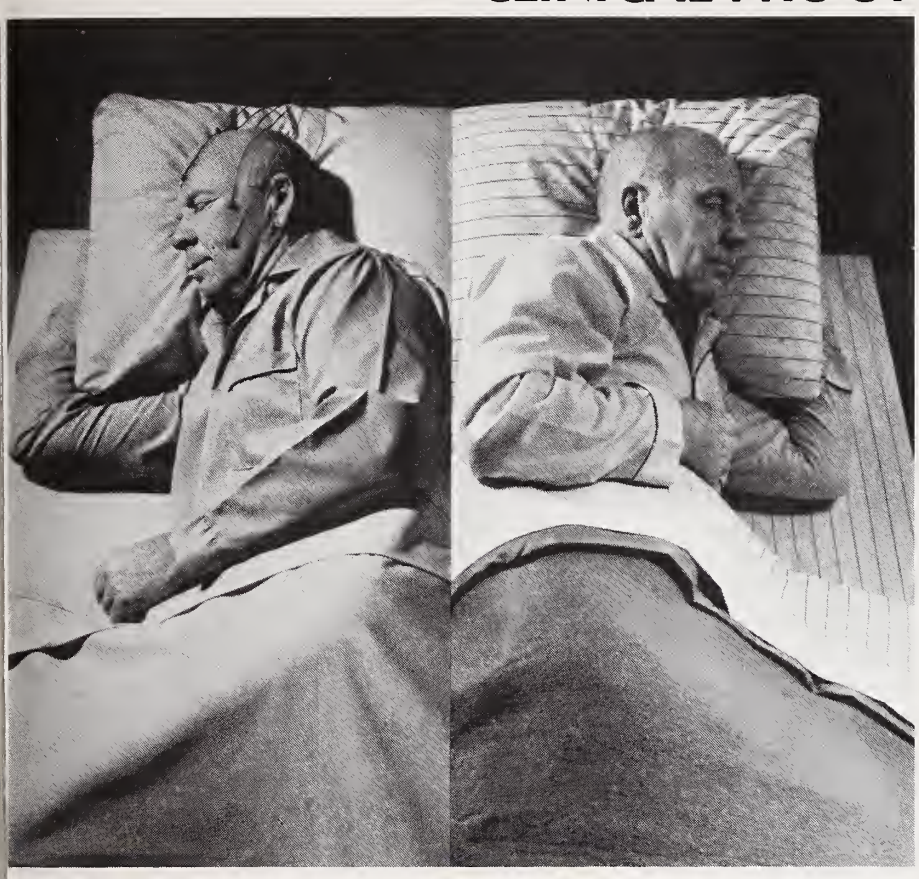
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- Undiminished efficacy for at least 28 consecutive nights[2-4]
- Patients usually awake rested and refreshed[7-9]
- Avoids causing early awakenings or rebound insomnia after discontinuation of therapy[2,5,10-12]

Caution patients about driving, operating hazardous machinery or drinking alcohol during therapy. Limit dose to 15 mg in elderly or debilitated patients. Contraindicated during pregnancy.

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flurazepam HCl/Roche

References: **1.** Kales J *et al*: *Clin Pharmacol Ther* 12:691-697, Jul-Aug 1971. **2.** Kales A *et al*: *Clin Pharmacol Ther* 18:356-363, Sep 1975. **3.** Kales A *et al*: *Clin Pharmacol Ther* 19:576-583, May 1976. **4.** Kales A *et al*: *Clin Pharmacol Ther* 32:781-788, Dec 1982. **5.** Frost JD Jr, DeLucchi MR: *J Am Geriatr Soc* 27:541-546, Dec 1979. **6.** Kales A, Kales JD: *J Clin Pharmacol* 3:140-150, Apr 1983. **7.** Greenblatt DJ, Allen MD, Shader RI: *Clin Pharmacol Ther* 21:355-361, Mar 1977. **8.** Zimmerman AM: *Curr Ther Res* 13:18-22, Jan 1971. **9.** Amrein R *et al*: *Drugs Exp Clin Res* 9(1):85-99, 1983. **10.** Monti JM: *Methods Find Exp Clin Pharmacol* 3:303-326, May 1981. **11.** Greenblatt DJ *et al*: *Sleep* 5(Suppl 1):S18-S27, 1982. **12.** Kales A *et al*: *Pharmacology* 26:121-137, 1983.

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Before prescribing, please consult complete product information, a summary of which follows:

Indications: Effective in all types of insomnia characterized by difficulty in falling asleep, frequent nocturnal awakenings and/or early morning awakening; in patients with recurring insomnia or poor sleeping habits; in acute or chronic medical situations requiring restful sleep. Objective sleep laboratory data have shown effectiveness for at least 28 consecutive nights of administration. Since insomnia is often transient and intermittent, prolonged administration is generally not necessary or recommended. Repeated therapy should only be undertaken with appropriate patient evaluation.

Contraindications: Known hypersensitivity to flurazepam HCl; pregnancy. Benzodiazepines may cause fetal damage when administered during pregnancy. Several studies suggest an increased risk of congenital malformations associated with benzodiazepine use during the first trimester. Warn patients of the potential risks to the fetus should the possibility of becoming pregnant exist while receiving flurazepam. Instruct patient to discontinue drug prior to becoming pregnant. Consider the possibility of pregnancy prior to instituting therapy.

Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants. An additive effect may occur if alcohol is consumed the day following use for nighttime sedation. This potential may exist for several days following discontinuation. Caution against hazardous occupations requiring complete mental alertness (*e.g.*, operating machinery, driving). Potential impairment of performance of such activities may occur the day following ingestion. Not recommended for use in persons under 15 years of age. Though physical and psychological dependence have not been reported on recommended doses, abrupt discontinuation should be avoided with gradual tapering of dosage for those patients on medication for a prolonged period of time. Use caution in administering to addiction-prone individuals or those who might increase dosage.

Precautions: In elderly and debilitated patients, it is recommended that the dosage be limited to 15 mg to reduce risk of oversedation, dizziness, confusion and/or ataxia. Consider potential additive effects with other hypnotics or CNS depressants. Employ usual precautions in severely depressed patients, or in those with latent depression or suicidal tendencies, or in those with impaired renal or hepatic function.

Adverse Reactions: Dizziness, drowsiness, lightheadedness, staggering, ataxia and falling have occurred, particularly in elderly or debilitated patients. Severe sedation, lethargy, disorientation and coma, probably indicative of drug intolerance or overdosage, have been reported. Also reported: headache, heartburn, upset stomach, nausea, vomiting, diarrhea, constipation, GI pain, nervousness, talkativeness, apprehension, irritability, weakness, palpitations, chest pains, body and joint pains and GU complaints. There have also been rare occurrences of leukopenia, granulocytopenia, sweating, flushes, difficulty in focusing, blurred vision, burning eyes, faintness, hypotension, shortness of breath, pruritus, skin rash, dry mouth, bitter taste, excessive salivation, anorexia, euphoria, depression, slurred speech, confusion, restlessness, hallucinations, and elevated SGOT, SGPT, total and direct bilirubins, and alkaline phosphatase; and paradoxical reactions, *e.g.*, excitement, stimulation and hyperactivity.

Dosage: Individualize for maximum beneficial effect. *Adults:* 30 mg usual dosage; 15 mg may suffice in some patients. *Elderly or debilitated patients:* 15 mg recommended initially until response is determined.

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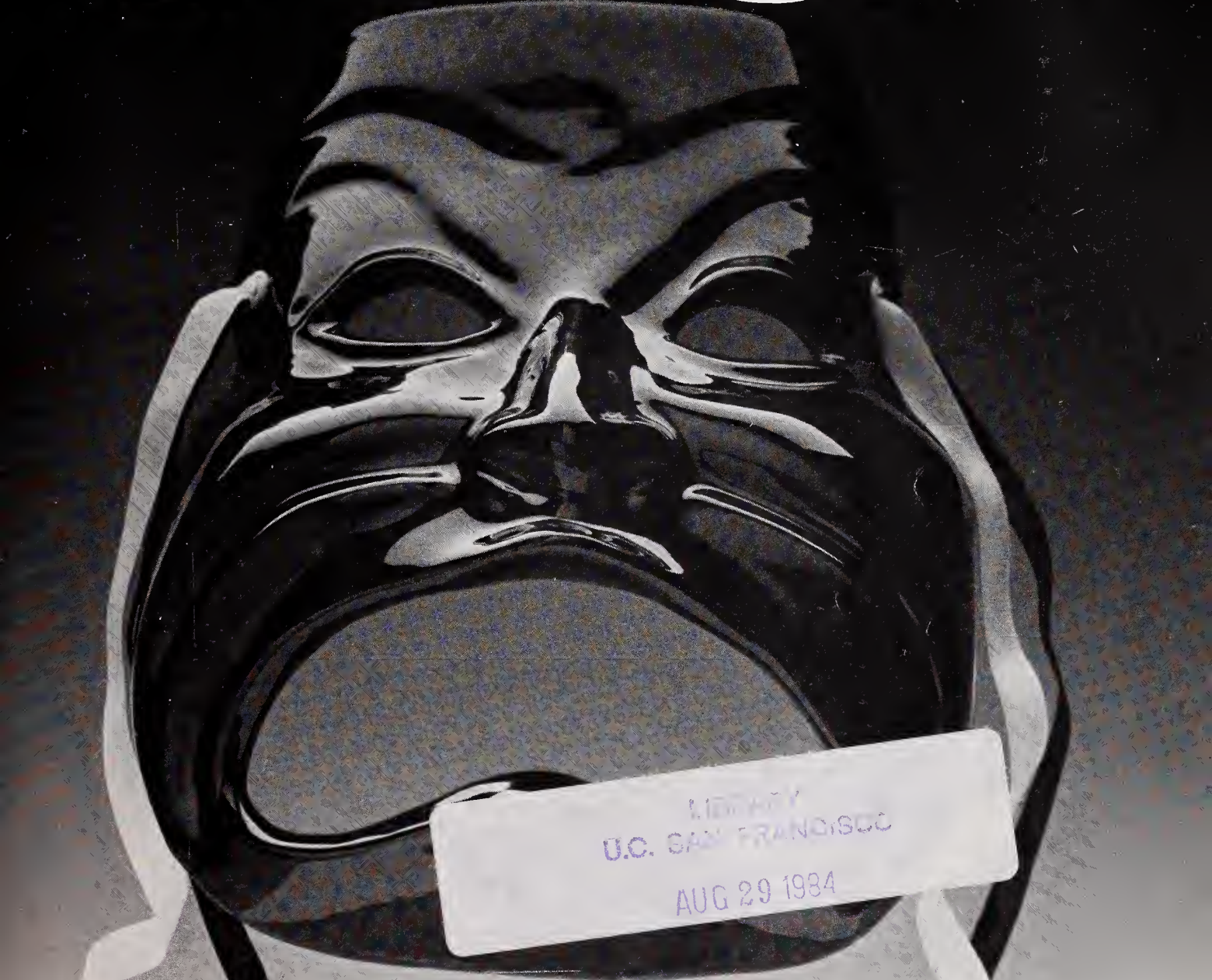
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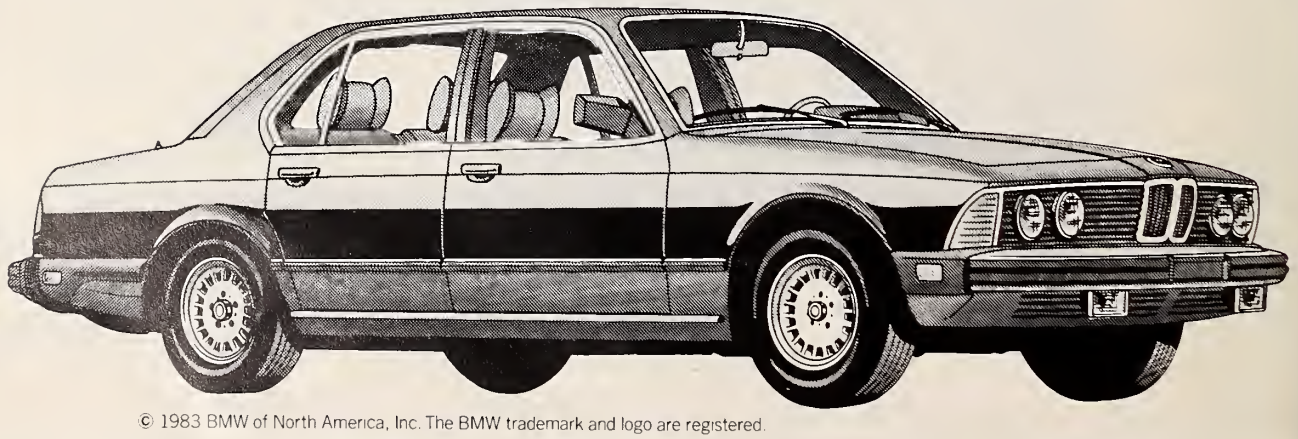
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BUSINESS MANAGER
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Established 1911. Owned and edited by the Medical Association of Georgia. Published monthly under the direction of the Board of Directors of the Association. Printed by The Ovid Bell Press, Inc., Fulton, Missouri.

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The subscription price per year for members of the Medical Association of Georgia is $7.50, included in the annual membership dues. The subscription price for nonmembers is $15.00 in the United States, Canada and Mexico, and $17.00 in other countries. Single copies are $2.

The *Journal of the Medical Association of Georgia* is published monthly at 938 Peachtree Street, N. E., Atlanta, GA 30309-3990. Second-class postage paid at Atlanta, Georgia, and at additional mailing offices. POSTMASTER: Send address changes to Medical Association of Georgia, 938 Peachtree Street, N. E., Atlanta, GA 30309-3990.

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Incidental Intelligence . . .

Medical Students Address Important Issues at National AMA Convention

The Medical Student Section (MSS) of the AMA House of Delegates convened in Chicago on June 15, 1984. During its 3-day meeting, the MSS examined many issues of present and future concern to the nation's physicians-in-training. Fourteen Georgians — two from Emory, five from the Medical College of Georgia, one from Mercer, and six from Morehouse — attended the MSS convention. The representation included voting delegates from all four Georgia medical schools. The MSS is composed of 230 representatives from medical schools around the country. Since its inception in 1978, the MSS has grown and matured, as it has learned to use effectively its power to introduce legislation onto the floor of the AMA House. This year the MSS passed along 9 resolutions to its parent organization. Subsequently, two of these were adopted, and six were referred for further study.

"Sallie Mae" Program

The House of Delegates passed MSS-introduced legislation that the AMA support the reauthorization of the Student Loan Marketing Association or a similar organization for student loan consolidation. The "Sallie Mae" program, as it is nicknamed, was inactivated during the Reagan administration in November, 1983. This organization assists medical school graduates in consolidating and refinancing various loans to help borrowers avoid default.

Dangers of Ultraviolet Light

The other MSS resolution adopted by the House of Delegates calls for the AMA to assemble and distribute information to physicians and to the public about the dangers of ultraviolet (UV) light from sun exposure, as well as the possibly harmful effects of the UV light used in commercial tanning centers. In view of the high sunlight-related incidence of skin cancer and of the possible phototoxicity and carcinogenicity of commercial tanning booths' UV-A light, the MSS felt that appropriate professional and lay education was warranted.

Foods, Stamps and Vitamins

MSS resolutions referred for further study by the AMA include a request that nutritional guidelines be set by the FDA to govern the use of federal food stamps. In addition, the AMA will study an MSS proposal that over-the-counter dietary supplements, such as vitamins, bear labels warning consumers of the toxic side effects of excessive dosages. The AMA will also research the MSS call for support of the provision of short-term emergency food aid from the United States to certain African nations facing eminent starvation.

Smoking and "Baby Doe"

The AMA will also study the MSS suggestion that supplements dealing with the adverse effects of smoking be prepared for inclusion in lay publications. Finally, the House of Delegates referred to committee an MSS resolution concerning the "Baby Doe" issue. The MSS asked that the AMA take an active role in developing hospital-based review councils to address ethical issues, including those involving handicapped persons, obviating the need for direct government intervention into such affairs.

Alcohol Counteradvertising

The House of Delegates referred for investigation an MSS resolution that the AMA develop model legislation (and support its passage) requiring that a percentage of alcohol advertising funds be provided for counteradvertising of the health consequences of alcohol abuse.

MSS-Related Activities

Several internal MSS measures set MSS policy on such issues as the illegal sale of medical diplomas, initiatives for medical student education in geriatric medicine, and government support for biomedical research training.

In addition to considering pertinent health care matters, the MSS also held educational workshops for its members. These four sessions addressed the future of Medicare, the AMA in health politics, residency training concerns, and how to organize statewide MSS chapters.

This year is especially important for the MSS, because for the first time a student seat has been created on the AMA Board of Trustees. Albeit a non-voting position, this seat provides important medical student representation in the nucleus of the AMA. Alice Chenault, a fourth-year student at the University of Alabama Medical School, was selected by the Medical Student Section to hold that office this year.

The MSS also appointed its national officers for the 1984-85 term. Two Georgia medical students received national posts. Leon Dent, a fourth-year student at the Morehouse School of Medicine in Atlanta, was elected to one of the five spots on the MSS Governing Council. He will serve this year as the voting MSS delegate to the AMA House. Dent currently holds the chairmanship of the Georgia MSS chapter. A native of Albany and a graduate of the University of Georgia, Dent has been actively involved in MSS since 1982.

Mark S. Litwin, a fourth-year student at the Emory University School of Medicine in Atlanta, was named national Editor of PULSE, the MSS segment that appears monthly in *JAMA*. A native of Charleston, South Carolina, and a graduate of Duke University, Litwin is also the Emory delegate to the MSS. He served a term as editor of the Emory medical school newspaper, ANLAGE.

As medical students take a more active role in organized medicine, they are helping mold the future of their profession. That future promises to be very different from the environment in which their predecessors trained.

Economic, ethical, and educational issues comprise much of the focus of MSS attention. The AMA Medical Student Section serves a vital purpose, involving the future leaders of American medicine at the outset of their professional careers in national medical concerns. The AMA continues to grow in strength and numbers, in large part due to an active and responsible Medical Student Section.

AIDS Blood Test Nears

Five companies have been chosen by the Department of Health and Human Services to develop a blood test for AIDS based on the virus discovery announced in May. These companies have been given the HTLV-III agent that has been called by researchers as the most likely candidate yet to be the cause of AIDS. They will produce it in quantity for antibody testing of HTLV-III in blood from patients with AIDS and others.

Development of the test is being monitored by the Food and Drug Administration's Blood Products Division — not as usually is the case with tests by the Medical Devices Division. This is supposed to ensure that besides the development of a test that works with some predictability, effort will be devoted to finding out what it means when an individual is antibody positive and what effect testing blood for transfusion for this virus and its antibody will do to the nation's blood supply.

MAG Auxiliary Summer Boards

Auxilians from all corners of Georgia met at Sea Palms Golf and Tennis Resort on St. Simons Island on June 25-26 for seminars, training sessions, and fellowship. The theme for 1984-85, "Build Today for a Better Tomorrow," was put into high gear as plans for a new auxiliary year were laid out.

The Summer Boards opened on Monday morning, June 25. After reports from the officers, the first workshop began. Mrs. Charles Hillis, of Lafayette, the Health Projects Chairman, conducted a session on the new Community Plan for Drug Abuse Prevention Project, a plan originated at PRIDE (Parents Resource Institute for Drug Education) at Georgia State University. The new plan involves three levels of action in a community — community alert, school cooperation, and parent education.

All of these involve not only the schools, but church and the business community. Mrs. Hillis displayed various sources of information which could be checked out on loan from the Auxiliary or bought directly from PRIDE. She encouraged county auxiliaries throughout the state to establish their own community plan for drug abuse prevention or to involve themselves in an already existing plan in their community. She was assisted in the presentation by representatives from Charter Medical of Atlanta.

The next workshop was conducted by Mrs. Lawrence Freant, of Macon, Learning Center Chairman, and Mrs. Alva Mayes, also of Macon, Mental Health Chairman, who introduced Phase III of the Learning Center, "Healthy Bodies, Healthy Minds — Happy People." Phase III complements the Drug Abuse Prevention Projects and will offer materials that school systems probably do not already have. The Learning Center is made up of activity workbooks, slides, records, bulletin board materials, film strips, books, and many other resource materials which ultimately teach children K-12 to have a better self concept. Teaching coping skills, moral values and judgments, learning to deal with stresses of life such as death, divorce, abuse, etc., are all a part of the information of Phase III. Mrs. Freant will be available to travel to counties to show this project to the local school boards, P.T.A. or any community group interested in purchasing this for their school system.

Following the Learning Center presentation, a guest speaker, Mr. William Killgallon, Chairman of the Board of Ohio Art Company, spoke on "Free Enterprise." After Mr. Killgallon's presentation, Mrs. Charles Thomas, from Athens, outlined the membership campaign for the new year, beginning with a Media-Legislative Recognition Day on October 10 in every town where there is an auxiliary. All doctor's spouses will be invited to attend, regardless of whether they are members of the state auxiliary or not. A phone-a-thon to contact all non-members is being planned, and late in the year there will be 12 personal growth seminars in various towns in the state where community skills will be emphasized.

The rest of the afternoon was spent in "breakout sessions" which included workshops for Presidents-elect, AMA-ERF Chairmen, Treasurers, Legislative Chairmen, and Revisions Committee. It was an afternoon of exchanging ideas and learning more effective ways of doing auxiliary work.

On Tuesday morning, Mr. Ken Williams and Ms. Sherry Waronker of the Public Relations Department of MAG led a seminar on MAG's and DHR's campaign on Child Abuse Prevention. They asked the county auxiliaries in the state to implement this project in their home communities. The goal of the project is to stimulate community and professional action and commitment to accept child abuse prevention as a community responsibility. With over 19,300 cases of child abuse reported in Georgia last year and a national estimate of at least 5,000 unreported cases in the state, the time is right to become active in a plan to reduce the incidence of child abuse.

Dr. Marion Howard, Director of the Teen Services Program at Grady Hospital, spoke to the group about the need for programs on teenage pregnancies. The aim of this series of programs is to present information regarding the general nature of relationships, sources of societal pressure influencing sexual behavior, and assertive responses which teens can use in peer pressure situations.

Next, was a report from Mrs. Dent Purcell, of Savannah, on the Auxiliary to the AMA Convention in Chicago. Then a brief business session was held before adjournment at noon.

Never before has the need for volunteers been so great. These programs planned for county auxiliaries are sorely needed, as they involve urgent matters in communities in Georgia. This is also an important year legislatively, as it is an election year. All members and prospective members need to work side by side as friends of medicine in our state. Doctors need to encourage their spouses to join our ranks and help them find time to help us promote better health care for all Georgians.

The Blues Restrict Coverage

In a year, the Blue Cross and Blue Shield Association will begin restricting its coverage of X-rays, CAT scans, and other diagnostic imaging procedures it believes to be medically unnecessary.

The use of diagnostic imaging procedures escalated 8% this year, and is expected to continue to climb. Many procedures are misutilized, overutilized, or redundant, said Blue Cross and Blue Shield Association President Bernard R. Tresnowski in June.

When a procedure is medically necessary and is justified in writing by the physician, the Association will pay for it. When medical necessity is in question, the case will be reviewed by a committee of Blue Cross and Blue Shield medical advisors. If the doctor and committee disagree, payment will be denied.

"Generally, we will pay the claim. But we'll be asking a lot more questions," said Tresnowski. The key recommendations of the guidelines are:

- Neither thermography nor diaphanography are recommended to evaluate suspected breast cancer or other breast disease.
- A CAT scan should not be used to evaluate minor headaches, but may be indicated in the case of unusual headaches suggesting a more serious brain disease.
- Ultrasound should not be used during pregnancy unless a specific problem is suspected.
- Routine chest X-rays are not recommended for any situation, including prenatal visits, hospital admissions or employment, except on the basis of individual history and physical examination or in testing for specific diagnosis.

FDA Calls For Warnings on Chymopapain

The checkered career of the enzyme chymopapain has received yet another setback. In the 18 months since the FDA approved this meat tenderizer for treating herniated discs, at least five patients have died and 28 others had adverse reactions when given chymopapain injections for disc lesions.

The finding prompted the Food and Drug Administration to get the manufacturers to send out a warning letter to physicians and issue a labelling change emphasizing the hazards. Not clear is whether the problems arose because the agent wasn't used properly or whether they are intrinsic to the therapy. Chymopapain digests protein and some patients had spontaneous aneurysms.

Drug Manufacturers Release Cost Study

The Pharmaceutical Manufacturers Association produced a cost-effectiveness study showing that a number of drugs when properly used are the least expensive forms of treatment for disease and overall substantially reduce costs of health care. Examples cited were glaucoma, preventing heart attacks, anti-ulcer therapy.

The study was the result of three years of work the PMA said. The findings, considering the source, are not particularly surprising. But the effort should be noted, this study is yet another move in a trend in the health care field — efforts to determine what's cost-effective and what isn't. Everyone's asking "what is the best buy?," and the health care field is no exception.

Ibuprofen Goes Over-The-Counter

The popular painkiller ibuprofen — marketed under the brand names Motrin and Rufen — will soon be available as an over-the-counter drug. The Food and Drug Administration approved non-prescription marketing of the drug on May 18.

The drug will be labeled for temporary relief of aches, pain from menstrual cramps, and fever reduction. Manufacturers say the drug causes less stomach irritation and less risk of overdose than aspirin.

One product, produced by Upjohn Co. and distributed by Bristol-Myers, will be called Nuprin. A second product, marketed by Whitehall Laboratories, will be sold as Advil. Both companies said distribution and advertising of the painkiller will begin as soon as possible.

New Cigarette Labels

After months of negotiating between health and tobacco groups, Congress is on the verge of approving explicit warning label legislation that stresses the specific risks of cigarette smoking.

If approved in June as expected, cigarette packages would contain a different warning every three months:

—"Smoking causes lung cancer, heart disease, emphysema, and may complicate pregnancy,"

—"Smoking by pregnant women may result in fetal injury, premature birth, and low birth weight infants," and

—"Cigarette smoke contains carbon monoxide."

The new labels would be printed in a heavily bordered rectangle 50% larger than the current label. Similar warnings would be used in cigarette advertisements on billboards.

Congress Passes Fee Freeze — With Sanctions

With virtually no substantive debate, Congress on June 27 approved a rigidly-monitored 15 month physician freeze expected to save Medicare $2.9 billion over the next three years.

The provision, attached to the FY85 budget bill, would require federal monitoring of every physician who did not sign a "participating physician" agreement. It would provide financial inducements for physicians who signed "participating physician" agreements committing them to assign all claims thereby accepting the frozen Medicare fee allowance as payment in full.

Nonparticipating physicians would be federally monitored. If a pattern of increasing fees to Medicare patients during the freeze was found, the physician could be fined up to $2,000 or "debarred" (suspended) from Medicare for up to five years.

The provision was concocted by Office of Management and Budget Director David Stockman and House conferees Reps. Andy Jacobs (D-IN), Henson Moore (R-LA) and Henry Waxman (D-CA) as a way out of an impasse over Senate resistance to House demands that any physician fee freeze be accompanied by mandatory assignment.

Responding to the committee action, the American Medical Association said that the new program would "intrude into the physician patient relationship for Medicare beneficiaries" and "is discriminatory toward a law abiding segment of physicians" and "patients who want to choose their physicians and have a voice in their own medical care."

The Medicare fee freeze is a major portion of the $6.5 billion in Medicare cuts included in the budget package of spending cuts and tax increases. Other major Medicare savings came from an increase in premiums and tighter limits on Medicare payments to hospitals. The package was approved 268 to 155 in the House and 83 to 15 in the Senate.

Until the conferees agreed to the new monitored freeze, the fee freeze and the premium increase had been major obstacles to passage of the budget bill. A Senate proposal would have frozen all fees for one year and then continued the freeze for a second year for physicians who didn't agree to accept all claims on assignment.

However, most House conferees were adamantly opposed to a freeze without mandatory assignment and still preferred a previously rejected House proposal tying a fee freeze to mandatory assignment of all inpatient claims. The House conferees wanted, at the very least, to "trigger" a mandatory assignment requirement if certain targets were exceeded.

The Reagan Administration had previously indicated that it would accept mandatory assignment if necessary to get the savings from a fee freeze, and Stockman entered the fracas when it appeared the freeze stalemate might kill the larger budget bill. The budget director called AMA Executive Vice President James Sammons, MD, and suggested that the AMA, then assembled for its annual meeting, agree to some form of mandatory assignment.

Bluntly informed by Dr. Sammons that mandatory assignment was a non-compromisable issue, Stockman continued to work behind the scenes, reportedly for adoption of a triggered mandatory assignment. Unyielding resistance to any form of mandatory assignment by Sen. Robert Dole (R-KS) and Senate conferees Sens. Max Baucus (D-MT), Lloyd Bentsen (D-TX) and John Danforth (R-MO) led to the development of the alternative.

It will:

—freeze Medicare customary and prevailing fees for all physicians for 15 months beginning July 1, 1984.

—establish a "participating physician" option for physicians who agree to accept all claims on assignment. Participating physicians could increase their billed charges to Medicare and although the fees they receive will remain frozen, the increased billings will be reflected in future fee screen updates.

—permit nonparticipating physicians to accept assignment on a case by case basis but monitor each physician comparing current charges to a three month base period compiled by Medicare carriers.

—fine up to $2000 plus the "overcharge" or bar from Medicare any "nonparticipating physician" found to have a pattern of increasing fees collected from Medicare patients.

Other provisions of the budget package would:

—move up to July 1, 1985 the due date for a report on the "advisability and feasibility" of physician DRGs.

—phase in a permanent national fee schedule for clinical laboratories and for lab services in physicians' offices. The fees would be set at 60% of the prevailing charges for the year beginning July 1, 1984.

—limit increases in Medicare's diagnosis related group reimbursement in fiscal 1985 to the rate of increase in the cost of the marketbasket of goods and services hospitals purchase.

—retain an expiring provision setting Medicare Part B premiums at 25% of program costs. This provision would increase the premium in 1986 to $19.10 a month as compared to $17.70 in current law.

—reject an increase in the Part B deductible.

—increase federal Medicaid payments for some pregnant women and children. The provision is a more limited version of Rep. Henry Waxman's (D-CA) Child Health Assurance (Assessment Program).

—reject an extension of current reductions in federal Medicaid payment to states.

—outline new guidelines for telephone monitoring of pacemakers that would take effect unless HHS issued new guidelines by October 1, 1984; establishing a pacemaker registry within FDA; and requiring HHS to review the appropriateness of Medicare payments to physicians for pacemaker implants.

—call for a physician reimbursement study by the Office of Technology. Objectives of the study — to be completed by December 31, 1985 — include suggestions for eliminating payment differences for cognitive and procedural care, increasing incentives for acceptance of assignment, and studying the "advisability or feasibility" of national or regional fee schedules.

MEDICAL MEETING CALENDAR

AUGUST

17-19—*Jekyll Island:* **Georgia Psychiatric Association Summer Meeting.** Category 1 credit. Contact J. Tom Sawyer, MAG, 938 Peachtree St., N.E., Atlanta 30309. PH:404/876-7535 or 1-800-282-0224 (toll free in Ga.).

23-26—*Hilton Head, SC:* **MAG Legislative Seminar.** Category 1 credit. Contact Hollie Ross, MAG, 938 Peachtree St., N.E., Atlanta 30309. PH:404/876-7535 or 1-800-282-0224 (toll free in Ga.).

23-26—*Virgin Islands:* **Fourth Annual Techniques Course in Arthroscopic Surgery.** Category 1 credit. Contact Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., NE, Ste. 110, Atlanta 30322. PH:404/329-5695.

SEPTEMBER

1-2—*Sea Island:* **Georgia Chapter, American College of Physicians Fall Meeting.** Category 1 Credit. Contact Malcolm Page, M.D., MCG, Augusta 30912. PH: 404-828-0211, Ext. 4078.

6-8—*Atlanta:* **Southeastern Occupational Health Conference.** Contact T. R. Hatfield, MD, P.O. Box 71, West Point 31833. PH:404/756-7111 ext. 2204.

7-8—*Atlanta:* **Office Urodynamics.** Contact Merrily Laube, Southern Found. for Edu. and Medical Research, Inc., 98 Currier St., Atlanta 30308. PH:404/688-3323.

12-14—*Savannah:* **Neonatology — The Sick Newborn.** Category 1 credit. Contact Div. of Cont. Ed., MCG, Augusta 30912. PH:404/828-3967.

13-15—*Atlanta:* **Introduction Into Percutaneous Transluminal Angioplasty IV.** Category 1 credit. Contact Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., NE, Ste. 110, Atlanta 30322. PH:404/329-5695.

14-16—*Hilton Head Island, SC:* **The Georgia Society of Anesthesiologists and the South Carolina Society of Anesthesiologists Fall Meeting.** Category 1 credit. Contact William Hammonds, Secy.-Treas., Ga. Society of Anesth., Emory Univ. Hosp., 1364 Clifton Rd., NE, Atlanta 30322. PH:404/321-0111.

16-20—*Atlanta:* **Demonstrations in Percutaneous Transluminal Angioplasty XII.** Category 1 credit. Contact Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., NE, Ste. 110, Atlanta 30322. PH:404/329-5695.

20-23—*Sea Island:* **Georgia Surgical Society Annual Meeting.** Category 1 credit. Contact William McGarity, MD, Emory Univ. Clinic, 1365 Clifton Rd., NE, Atlanta 30322. PH:404/321-0111 x 3322.

23-26—*Sea Island:* **Georgia Urological Association Annual Meeting.** Contact Richard Estes, MD, Secy.-Treas., 35 Collier Rd., NW, Ste. 700, Atlanta 30308. PH:404/355-0813.

28-30—*St. Simons Island:* **Georgia Gastroenterologic Society Annual Scientific Sessions.** Category 1 credit. Contact Theodore Hersh, MD, Emory Clinic, 1365 Clifton Rd., NE, Atlanta 30322. PH:404/321-0111.

OCTOBER

4-6—*Atlanta:* **Endourology.** Contact Merrily Laube, Southern Found. for Edu. and Medical Research, Inc., 98 Currier St., Atlanta 30308. PH:404/688-3323.

4-6—*Hilton Head Island, SC:* **Frontiers in Nutrition** (cosponsored with Vanderbilt Univ. Sch. of Med.) AMA Category 1 and AAFP prescribed credit. Contact Div. of Cont. Ed., MCG, Augusta 30912. PH:404/828-3967.

10-11—*Atlanta:* **The Risks and Benefits of Family Planning.** Category 1 credit. Contact Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., NE, Ste. 110, Atlanta 30322. PH:404/329-5695.

15-20—*Augusta:* **Obstetrics & Gynecology.** Category 1 credit. Contact Div. of Cont. Ed., MCG, Augusta 30912. PH:404/828-3967.

18-21—*Sea Island:* **Georgia Orthopaedic Society Annual Meeting.** Category 1 credit. Contact William C. Collins, M.D., Secy.-Treas., GOS, 993 Johnson Ferry Rd., NE, Ste. 100, Atlanta 30342. PH:404/255-4582.

24-26—*Atlanta:* **Skeletal Radiology.** Category 1 credit. Contact Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., NE, Atlanta 30322. PH:404/329-5695.

24—*Columbus:* **Day of Endocrinology.** Category 1 and AAFP prescribed credit. Contact Judy Anderson, Int. Med. Found., P.O. Box 311, Columbus 31902-0311. PH:404/571-1454.

28-31—*Helen:* **Psychiatric Institute on Group Behavior and Group Leadership.** Category 1 credit. Contact Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., NE, Ste. 110, Atlanta 30322. PH:404/329-5695.

29-31—*Augusta:* **Cranial Ultrasound.** Category 1 credit. Contact Div. of Cont. Ed., MCG, Augusta 30912. PH:404/828-3967.

NOVEMBER

4-7—*New Orleans, LA:* **Southern Medical Association 78th Annual Scientific Assembly.** Contact Southern Med. Assn., 2601 Highland Ave., Birmingham, AL 35201.

5-10—*Atlanta:* **American Society of Cytology.** Contact ASC, 130 S. 9th St., Ste. 810, Philadelphia, PA 19107. PH:215/922-3880.

11-16—*Atlanta:* **American Academy of Ophthalmology.** Contact AAO, P.O. Box 7424, 1833 Filmore St., San Francisco, CA 94120. PH:415/921-4700.

15-18—*Atlanta:* **Georgia Academy of Family Physicians' Annual Meeting.** Category 1 and AAFP prescribed credit. Contact Camille Day, Exec. VP, GAFP, 11 Corporate Sq., Ste. 205, Atlanta 30329. PH:404/321-7445.

16-18—*Atlanta:* **MAG Scientific Assembly.** Category 1 credit. Contact Stephen Davis, Dir. of Ed., MAG, 938 Peachtree St., N.E., Atlanta 30309. PH:404/876-7535 or 1-800-282-0224 (toll free in Ga.).

28-Dec. 2—*Atlanta:* **Ninth Southeastern Conference on Alcohol and Drug Abuse.** Contact Barbara Turner, Charter Med. Corp., Addictive Disease Div., 5780 Peachtree-Dunwoody Rd., N.E., #170, Atlanta 30342.

DECEMBER

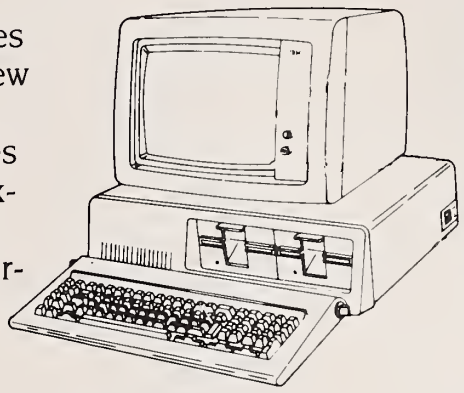
1-2—*Atlanta:* **Regional Anesthesia: Surgery, Obstetrics, and Pain.** Category 1 credit. Contact Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., NE, Ste. 110, Atlanta 30322. PH:404/329-5695.

3-7—*Atlanta:* **MKSAP VI Review Course.** Category 1 credit. Contact Registrar, Amer. Coll. of Phy., 4200 Pine St., Philadelphia, PA 19104. PH:800/523-1546.

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All day Sunday, August 19 ..... 8:30 to 4:30

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All day Thursday, August 23 ..... 8:30 to 4:30

Volkswriter Deluxe (4 hours — $65)
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Wednesday afternoon, August 8 ..... 1:00 to 5:00
Wednesday evening, August 15 ..... 6:00 to 10:00

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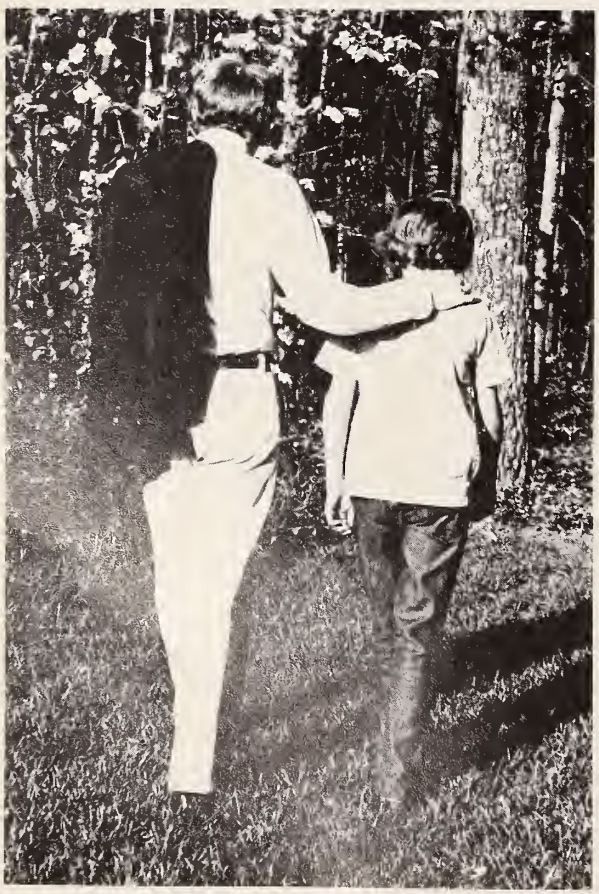
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Contraindications: Concomitant use with other potassium-sparing agents such as spironolactone or amiloride. Further use in anuria, progressive renal or hepatic dysfunction, hyperkalemia. Pre-existing elevated serum potassium. Hypersensitivity to either component or other sulfonamide-derived drugs.

Warnings: Do not use potassium supplements, dietary or otherwise, unless hypokalemia develops or dietary intake of potassium is markedly impaired. If supplementary potassium is needed, potassium tablets should not be used. Hyperkalemia can occur, and has been associated with cardiac irregularities. It is more likely in the severely ill, with urine volume less than one liter/day, the elderly and diabetics with suspected or confirmed renal insufficiency. Periodically, serum K^+ levels should be determined. If hyperkalemia develops, substitute a thiazide alone, restrict K^+ intake. **Associated widened QRS complex or arrhythmia requires prompt additional therapy.** Thiazides cross the placental barrier and appear in cord blood. Use in pregnancy requires weighing anticipated benefits against possible hazards, including fetal or neonatal jaundice, thrombocytopenia, other adverse reactions seen in adults. Thiazides appear and triamterene may appear in breast milk. If their use is essential, the patient should stop nursing. Adequate information on use in children is not available. Sensitivity reactions may occur in patients with or without a history of allergy or bronchial asthma. Possible exacerbation or activation of systemic lupus erythematosus has been reported with thiazide diuretics.

Precautions: Do periodic serum electrolyte determinations (particularly important in patients vomiting excessively or receiving parenteral fluids, and during concurrent use with amphotericin B or corticosteroids or corticotropin [ACTH]). Periodic BUN and serum creatinine determinations should be made, especially in the elderly, diabetics or those with suspected or confirmed renal insufficiency. Cumulative effects of the drug may develop in patients with impaired renal function. Thiazides should be used with caution in patients with impaired hepatic function. They can precipitate coma in patients with severe liver disease. Observe regularly for possible blood dyscrasias, liver damage, other idiosyncratic reactions. Blood dyscrasias have been reported in patients receiving triamterene, and leukopenia, thrombocytopenia, agranulocytosis, and aplastic and hemolytic anemia have been reported with thiazides. Thiazides may cause manifestation of latent diabetes mellitus. The effects of oral anticoagulants may be decreased when used concurrently with hydrochlorothiazide; dosage adjustments may be necessary. Clinically insignificant reductions in arterial responsiveness to norepinephrine have been reported. Thiazides have also been shown to increase the paralyzing effect of nondepolarizing muscle relaxants such as tubocurarine. Triamterene is a weak folic acid antagonist. Do periodic blood studies in cirrhotics with splenomegaly. Antihypertensive effects may be enhanced in post-sympathectomy patients. Use cautiously in surgical patients. Triamterene has been found in renal stones in association with the other usual calculus components. Therefore, 'Dyazide' should be used with caution in patients with histories of stone formation. A few occurrences of acute renal failure have been reported in patients on 'Dyazide' when treated with indomethacin. Therefore, caution is advised in administering nonsteroidal anti-inflammatory agents with 'Dyazide'. The following may occur: transient elevated BUN or creatinine or both, hyperglycemia and glycosuria (diabetic insulin requirements may be altered), hyperuricemia and gout, digitalis intoxication (in hypokalemia), decreasing alkali reserve with possible metabolic acidosis. 'Dyazide' interferes with fluorescent measurement of quinidine. Hypokalemia is uncommon with 'Dyazide', but should it develop, corrective measures should be taken such as potassium supplementation or increased dietary intake of potassium-rich foods. Corrective measures should be instituted cautiously and serum potassium levels determined. Discontinue corrective measures and 'Dyazide' should laboratory values reveal elevated serum potassium. Chloride deficit may occur as well as dilutional hyponatremia. Concurrent use with chlorpropamide may increase the risk of severe hyponatremia. Serum PBI levels may decrease without signs of thyroid disturbance. Calcium excretion is decreased by thiazides. 'Dyazide' should be withdrawn before conducting tests for parathyroid function.

Thiazides may add to or potentiate the action of other antihypertensive drugs.

Diuretics reduce renal clearance of lithium and increase the risk of lithium toxicity.

Adverse Reactions: Muscle cramps, weakness, dizziness, headache, dry mouth; anaphylaxis, rash, urticaria, photosensitivity, purpura, other dermatological conditions; nausea and vomiting, diarrhea, constipation, other gastrointestinal disturbances; postural hypotension (may be aggravated by alcohol, barbiturates, or narcotics). Necrotizing vasculitis, paresthesias, icterus, pancreatitis, xanthopsia and respiratory distress including pneumonitis and pulmonary edema, transient blurred vision, sialadenitis, and vertigo have occurred with thiazides alone. Triamterene has been found in renal stones in association with other usual calculus components. Rare incidents of acute interstitial nephritis have been reported. Impotence has been reported in a few patients on 'Dyazide', although a causal relationship has not been established.

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J-4044 January 1984

JOURNAL
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Acquired Immunodeficiency Syndrome: Highlights on the Diagnosis and Management of Opportunistic Infections

CARLOS E. LOPEZ, M.D., *Atlanta**

Abstract

The acquired immunodeficiency syndrome (AIDS) is complicated by a series of infectious and neoplastic events that occur as a result of a profound defect of the cell-mediated immune system. Recent work suggests that AIDS is only the most severe end of the clinical spectrum of infection with a retrovirus (HTLV-III) and that milder forms of infection, such as AIDS-related complexes (ARCs), and asymptomatic carriers occur. In view of its clearly worse prognostic implications, the term AIDS should be reserved for those patients with *documented* opportunistic infections or Kaposi's sarcoma. Under no circumstances should a patient be told he or she has AIDS based on a high level of suspicion alone or just because of an abnormal immunologic profile.

Case Reports

CASE 1: A previously healthy 52-year-old white male became ill with *Pneumocystis carinii* pneumonia which failed to respond to trimethoprim-sulfamethoxazole, or pentamidine treatment. Disseminated herpes simplex infection developed, and the patient died 5 weeks after onset of illness.

* Dr. Lopez specializes in infectious diseases and is with the Department of Medicine, Piedmont Hospital, Atlanta, GA. Send reprint requests to him at 1938 Peachtree Rd., NW, Ste. 204, Atlanta, GA 30309.

CASE 2: A previously healthy 30-year-old white male experienced an illness characterized by refractory perineal herpes simplex infection, followed by Kaposi's sarcoma of the oral mucosa, cytomegalovirus retinitis with blindness, and primary CNS lymphoma, leading to death 8 months after initial onset of illness.

CASE 3: A previously healthy 31-year-old white male developed refractory and progressive gluteal and rectal herpes simplex infection. In subsequent months, he developed *Pneumocystis carinii* pneumonia, cytomegalovirus viremia and retinitis, disseminated *Mycobacterium avium* infection, and terminal cytomegalovirus encephalitis and pneumonia leading to death 1 year after onset of illness.

CASE 4: A previously healthy 31-year-old white male had onset of cryptococcal meningitis and *Pneumocystis carinii* pneumonia. Four months after successful treatment, he experienced pulmonary cryptococcosis with recurrent meningeal infection, disseminated varicella zoster, and disseminated *Mycobacterium avium* infection, with terminal nonspecific encephalitis leading to death 6 months after onset of illness.

CASE 5: A previously healthy 26-year-old white male experienced intermittent diarrhea and 35 lbs. of weight loss. Disseminated *Mycobacterium avium* infection was found, with massive infiltration of the small bowel and retroperitoneal lymph nodes. Cryptococcal meningitis and disseminated herpes simplex infection developed, followed by encephalitis

and blindness. The patient died 1 year after onset of illness.

CASE 6: A previously healthy 32-year-old white male had onset of *Pneumocystis carinii* pneumonia unresponsive to trimethoprim-sulfamethoxazole or pentamidine treatment and died 5 weeks after onset of illness.

CASE 7: A previously healthy 42-year-old white male experienced hemiparesis and dysarthria due to *Toxoplasma* encephalitis of the thalamic region. He responded to treatment with neurologic and radiographic improvement but developed a diffuse encephalitis and pneumonia leading to death 6 months after onset of illness.

CASE 8: A previously healthy 31-year-old white male presented with a 6-month history of fatigue, about 30 lbs. of weight loss, anemia, and fever. Progressive dyspnea developed over a 4-week period. Although chest x-ray was normal, he had a reduced lung diffusion capacity and a markedly high gallium lung uptake; *Pneumocystis carinii* was found on bronchoscopy. He developed marked leukopenia with trimethoprim-sulfamethoxazole, but responded well to pentamidine treatment. He later developed primary CNS lymphoma and small bowel perforation due to cytomegalovirus infection, leading to death 8 months after onset of illness.

CASE 9: A previously healthy 32-year-old white male presented with a 2-week history of progressive dysphagia and odynophagia. Invasive *Candida* esophagitis was diagnosed; the patient responded well to ketoconazole treatment.

CASE 10: A previously healthy 34-year-old white male presented with *Pneumocystis carinii* pneumonia 18 months after the initial diagnosis of cutaneous lymphatic and gastrointestinal Kaposi's sarcoma without opportunistic infections. He responded well to pentamidine treatment.

Patients with AIDS have a profound depression of their cellular immune system due specifically to depletion and functional impairment of the T-helper lymphocytes.

The above case histories describe part of the spectrum and course of illness in patients with acquired immunodeficiency syndrome (AIDS), a disease of probable viral etiology with an inexorably fatal course. Five years since the first case of AIDS was detected in the United States and as of May 21, 1984, a total of 4,534 cases of severe cellular immunodeficiency with opportunistic infections and/or Kaposi's sarcoma have been reported to the U.S. Public Health Service's Centers for Disease Control (CDC); the total number of cases has been doubling every 6 months. Although AIDS has occurred primarily among male homosexuals or bisexuals (72%), cases have also been described among intravenous (IV) drug users (17%), Haitian immigrants (4%), hemophiliacs, sexual contacts of individuals in the above risk categories, or as a result of neonatal transmission or blood transfusion. A small number of cases of AIDS do not clearly fit into any of the above risk categories. The distribution of cases in the United States is wide, but the majority (65%) have been reported from New York State and California. In Georgia, 53 cases of AIDS had been reported to the Georgia Department of Human Resources' Division of Epidemiology as of May 29, 1984. The majority were from the Atlanta area, and they occurred in male homosexuals (74%), IV drug users (15%), or other risk groups (11%).

Although trimethoprim-sulfamethoxazole is relatively nontoxic in other patients, serious adverse reactions occur commonly in AIDS patients.

The catastrophic nature of AIDS, the exponential increase in the number of cases, the presence of a large population at risk, and the unresolved question of the exact modes of spread of this seemingly transmissible illness explain the high level of concern and apprehension about this disease in the community. As practicing physicians, we are faced with the need to evaluate those patients who are concerned about the possibility of AIDS — sometimes for legitimate reasons, other times as a result of unwarranted fear. Since there is not as yet a laboratory marker of the disease readily available to practicing physicians, the diagnosis of AIDS will still depend entirely on the fulfillment of strict clinical criteria (See Case Definition below). An appropriate evaluation requires attention to clinical manifestations, epidemiologic or risk factors, and familiarity with the value and limitations of available diagnostic procedures. At no time should a patient be told he or she has AIDS based on a high level of suspicion only. Nor should the term pre-AIDS be used, implying certainty of the eventual development of the fatal syndrome in those patients with symptoms (e.g., fatigue, fever, weight loss, diarrhea) or allied syndromes (e.g., idiopathic thrombocytopenic purpura, chronic lymphadenopathy) but who fail to fulfill the case definition of AIDS, even when there are laboratory markers of cellular immunodeficiency. AIDS-related complexes (ARC) is a better term for these "incomplete" syndromes, since follow-up of these patients over an extended period of time has shown that AIDS has not developed in the majority (over 80%). These represent part of the clinical spectrum of infection with the proposed AIDS agent, which

appears to range from an asymptomatic phase to a stage that includes those afflicted with AIDS (See section on Etiology).

In what follows, the author highlights some aspects of the diagnosis and management of patients with AIDS, but this does not constitute an exhaustive review of the subject. New knowledge about the disease is rapidly accumulating, and publications on AIDS have appeared at a rate of over 80 per month in recent months. Reviews on the subject have appeared recently.[1-3]

Case Definition

The Centers for Disease Control defines a case of AIDS based on strict clinical criteria (See Table 1). A strict clinical case definition like this will likely include only the severe end of the spectrum of infection with the proposed AIDS infectious agent (''the tip of the iceberg''), and does not include milder prodromal or asymptomatic forms of infection. It is possible that as our understanding of the nature of AIDS increases, other disease entities may well fall within its clinical spectrum. It is also very likely that in the future, other syndromes will be added to the ranks of the AIDS-related complexes.

Table 1 — Centers for Disease Control Case Definition of Acquired Immunodeficiency Syndrome

1. Presence of a reliably diagnosed disease at least moderately indicative of underlying cellular immunodeficiency (Kaposi's Sarcoma in a patient < 60 years of age, *Pneumocystis carinii* pneumonia, other serious opportunistic infections).

2. Absence of known causes of underlying immunodeficiency, such as immunosuppressive therapy or lymphoreticular malignancy.

General Clinical Syndromes

Opportunistic infections were the sole manifestation of AIDS in 68.5% of 4,534 patients reported to the CDC as of May 21, 1984, while 6.6% of patients presented with *Pneumocystis carinii* pneumonia and Kaposi's sarcoma. Kaposi's sarcoma was the sole manifestation of AIDS in 25%. *Pneumocystis carinii* pneumonia remains the most frequent serious opportunistic infection of AIDS, occurring in about 70% of 125 patients with AIDS and opportunistic infections at the New York University Medical Center.[4] This was followed by 14% each of clinically evident cytomegalovirus and *Mycobacterium avium* infections. The incidence of other infections was 12% cryptococcus, 8% each of toxoplasmosis and *Mycobacterium* tuberculosis, 1% herpes simplex and 4% *Legionella pneumophila*. Multiple infections occurred in 35% of patients in the above series.

Local Cutaneous Infections

Besides the major infectious syndromes mentioned above, a number of local cutaneous infections occur in AIDS, and these may precede the major infectious or neoplastic complications. Although these infectious processes are not diagnostic of AIDS, they may signal those patients in whom serious opportunistic infections may eventually develop. Besides severe, progressive perianal or perioral herpes simplex infection, which is a major marker of AIDS, severe refractory herpes labialis, stomatitis, or pharyngitis may occur. In addition, herpes simplex infection involving the nasal antrum, gluteal, lower abdominal, and penile regions are also seen. Rapidly enlarging venereal warts (human papilloma virus infection) of the penile or anorectal

Local cutaneous infections may precede the major infectious or neoplastic complications of AIDS.

region have been observed, and involvement of nongenital areas such as the face and neck may take the form of multiple flat or filiform warts. *Molluscum contagiosum* may produce widespread lesions in the genital, rectal, and lower abdominal regions, with involvement of the head, neck, and trunk in some patients. Repeated episodes of oral *Candida albicans* infections (thrush) are commonplace in AIDS patients, and unusually severe cutaneous fungal infections with *Candida* and the dermatophytes are also seen. Extensive *Staphylococcus aureus* dermatitis may occur in the form of furunculosis or impetigo. Bullous impetigo may become quite extensive without treatment, and it is mandatory that the bacterial nature of these infections be documented by culture and that disseminated varicella zoster or herpes simplex infection be ruled out with at least a Tzanck smear and if possible viral culture from the base of a freshly opened lesion.

Pneumocystis Carinii Pneumonia

Pneumocystis carinii pneumonia (PCP) is the most common life-threatening infectious complication occurring in patients with AIDS, and it may present as either an insidious subacute illness or run an acute fulminant course. Most patients present with fever, dyspnea, mid-chest discomfort or tightness, and nonproductive cough. Hypoxemia may or may not be present even in the face of a markedly reduced lung diffusion capacity (DLCO). Chest radiograph will frequently be abnormal, showing a diffuse reticulo-nodular pattern which may progress to alveolar consolidation. Some patients may present with severe chest symptoms, but the chest x-ray may remain normal. The finding of a markedly reduced lung diffusion capacity is a reliable marker of extensive interstitial lung involvement in these patients, confirmed by an elevated ^{67}Gallium lung index (Figure 1).



^{67}Gallium (Ga) scan showing a high lung index (left) in a markedly dyspneic 31-year-old white male with confirmed *Pneumocystis carinii* infection on bronchial lavage and in whom chest x-ray was normal. The figure on the right is included for comparison and shows a normal ^{67}Ga study in another patient.

The diagnosis of PCP requires demonstration of the parasite in either bronchial secretions or lung tissue. Open lung biopsy is rarely necessary except when the diagnosis cannot be made by bronchoscopy or when other pathology is suspected. It must be emphasized that in view of the occasional absence of the foamy alveolar appearance of classic PCP in these patients, a methenamine silver stain should be performed routinely on biopsy specimens from these patients to rule out a strictly interstitial *Pneumocystis* infection. Bronchoalveolar lavage is the most sensitive non-invasive method of diagnosis in some hands, and may be superior to bronchial brushings or transbronchial lung biopsy in AIDS patients with pneumocystosis. Demonstration of the organism is most often done by methenamine silver stain, which shows the cyst forms of the parasite. Giemsa stain will show the internal sporozoites of *Pneumocystis* and may be used for more rapid diagnosis by examination of touch smears of brush or biopsy specimens.

Pneumocystis carinii *pneumonia remains the most frequent serious opportunistic infection of AIDS, followed by Kaposi's sarcoma.*

The treatment of PCP in AIDS patients presents some unique problems. The only two established drugs for the treatment of PCP are trimethoprim sulfamethoxazole (TMX) and pentamidine isethionate. Both drugs are equally effective, with improvement seen in 60-70% of patients. Although TMX is relatively nontoxic in other patients, serious adverse reactions occur commonly in patients with AIDS, frequently requiring discontinuation of treatment. Fever, rash, granulocytopenia, thrombocytopenia, and liver function abnormalities are the most frequent adverse reactions seen in AIDS patients receiving TMX. The addition of folinic acid, 10 mgs. daily, may theoretically reduce the hematologic toxicity of TMX in AIDS. Pentamidine is predictably nephro-toxic, but this effect is usually reversible. Other side effects of pentamidine include hypotension and hypoglycemia; sterile abscesses may occur at the injection sites. Profound thrombocytopenia may be seen in pentamidine-treated patients; more recently, marked granulocytopenia was reported.[5] Treatment for PCP should be given for at least 14 days, but a 3-week course of treatment is preferable. Combined use of pentamidine and TMX is controversial but should probably not be used because of possible antagonism.[6] Because of the high relapse rate of PCP (about 20%) in these patients with irreversible cellular immunodeficiency, consideration may be given to attempt long-term prophylaxis. Although TMX may appear as the ob-

vious choice for prophylaxis against PCP, the high frequency of toxic drug reactions seen in AIDS patients may limit its usefulness.

Difluoromethylornithine (DFMO) has shown promise as an alternative agent for the treatment of PCP in AIDS patients. This drug is presently available only through its clinical investigator (Dr. Jeffrey Golden, University of California, San Francisco) for the treatment of pentamidine and TMX failures.

Mycobacterial Infections

One of the most unique features of AIDS is that infections that were seldom seen before the epidemic are now a frequent occurrence among these patients and present a great challenge in management. A disseminated form of infection with *Mycobacterium avium-intracellulare,* an atypical *Mycobacterium* of Runyon's group III, is a good example of this. It ranks among the three most common systemic infections occurring in patients with AIDS, together with *Pneumocystis* and cytomegalovirus infections.

The most frequent clinical findings in patients with disseminated *M. avium-intracellulare* (MAI) infection are unexplained fever, pancytopenia, and liver function abnormalities. The diagnosis is most often made by bone marrow examination and less often by lymph node biopsy, liver biopsy, or blood culture. It is imperative that tissue obtained from patients with AIDS be stained for mycobacteria even in the absence of granulomata, since the latter are frequently absent in patients with MAI.

One of the most unique features of AIDS is that infections that were seldom seen before the epidemic are now a frequent occurrence among these patients . . . e.g., disseminated infection with **Mycobacterium avium-intracellulare.**

A unique finding of MAI in some patients with AIDS is that of massive infiltration of the lamina propria of the small bowel with tissue histiocytes loaded with acid-fast bacilli.[7] The latter also stain with periodic acid schiff (PAS) stain in a way similar to Whipple's disease, and the term pseudo-Whipple's disease has been used referring to these AIDS cases of MAI infection with small bowel infiltration. These patients may present with diarrhea, weight loss, and malabsorption. A clue to the presence of pseudo-Whipple's disease in these patients may be a malabsorptive pattern on small bowel x-ray series and an abnormal D-xylose absorption test. A small bowel biopsy is needed for confirmation. Acid-fast bacilli may be present in the stools of some of these patients, but the sensitivity of stool acid fast smears in patients with MAI and small bowel involvement is not known.

The results of treatment of MAI in AIDS patients have been disappointing. *M. avium-intracellulare* is inherently resistant to all conventional antituberculous drugs. Two promising agents (ansamycin and clofazimine) are available, with good in-vitro activity against *M. avium-intracellulare.* Ansamycin is a rifampin analogue and is currently available through the Centers for Disease Control in Atlanta (Tel. 404-329-3311). The treatment of MAI infection in AIDS patients with ansamycin plus two other anti-tuberculous drugs (usually isoniazid plus either ethambutol or streptomycin) results in clinical response in some patients. In spite of therapy, however, most patients eventually succumb to this or other opportunistic infections. Clofazimine (Lamprene) is an anti-leprosy drug with good in-vitro activity against *M. avium-intracellulare,* and trials are underway using it with ansamycin for the treatment of MAI. Clofazimine may be obtained after FDA approval of an investigational new drug (IND) request from the physician, by contacting Robert R. Jacobson, MD, PhD, at the National Hansen's Disease Center, in Carville, Louisiana.

Cytomegalovirus Infections

Systemic, progressive infections with cytomegalovirus (CMV) are commonly seen in patients with AIDS. This is particularly true of AIDS occurring in homosexual patients and probably reflects the known high prevalence of seroreactivity to CMV in this population.[8] Serology for CMV in AIDS is helpful only to the extent of confirming *latent infection* with the virus. The diagnosis of a significant infection must rely on clinical findings, culture, and histologic data, since even fulminant disease can occur in the presence of low or falling CMV titers.

Ocular involvement by CMV may produce progressive hemorrhagic retinitis and retinal detachment and may lead to blindness. Retinal soft (or cotton/wool) exudates are the earliest findings in these patients, but they are nonspecific. Only hemorrhagic retinitis can be considered characteristic of CMV infection in patients with AIDS. Nonspecific retinal cotton/wool exudates are a common but nondiagnostic finding in patients with AIDS, and these may precede the clinical manifestations of the disease. These cotton/wool spots may be transient only to reappear later. They are not associated with any specific infectious process or visual deficit and are felt to be due to arteriolar vasculitis. Progressive retinal involvement, however, should lead to suspicion of opportunistic infection such as CMV, systemic mycosis (e.g., cryptococcosis), or *Toxoplasma* endophthalmitis.[9]

Disseminated CMV infection in AIDS patients is

a progressive multisystem disease which may include encephalitis, pneumonitis, and adrenal insufficiency due to adrenal necrosis. CMV enterocolitis may be seen as part of the progressive disseminated syndrome or as an isolated event. Isolated gastrointestinal ulceration may be the sole manifestation of CMV infection, and rectosigmoid ulcers may mimic amebic colitis. A diffuse colitis has also been described. Patients with CMV enterocolitis may present with diarrhea and fecal leukocytosis, gastrointestinal bleeding, and intestinal perforation. Stool viral cultures are seldom helpful, but biopsy of involved areas showing the characteristic intranuclear inclusions may be useful in diagnosis. In those patients where proctosigmoidoscopy proves unrevealing, an abdominal gallium scan may show increased uptake in the involved areas of the large bowel, which may be amenable for biopsy by fiberoptic colonoscopy.

Disseminated cytomegalovirus infection in AIDS patients is a progressive multisystem disease which may include encephalitis, pneumonitis, and adrenal insufficiency due to adrenal necrosis.

There is no effective agent available for the treatment of cytomegalovirus infection. Isolated CMV retinitis may be slowly progressive over several months without significant visual deficit except when central vision is involved or when retinal detachment develops. Isolated CMV colitis may also evolve over a period of weeks or months and may not pose a major management problem except when bleeding or perforation occur. In disseminated CMV infection with encephalitis, the patient may become bedridden with progressive psycho-motor retardation, dementia, and inanition.

Toxoplasmosis and Other Neurologic Complications

Neurologic syndromes occur frequently during the course of illness in patients with AIDS. These were observed in 50 (31%) of 160 patients evaluated at Memorial Sloan-Kettering Cancer Center — New York Hospital.[10] A diffuse *subacute encephalitis* probably due to cytomegalovirus infection is the most common neurologic complication in these patients, manifesting by progressive psycho-motor retardation and dementia. Brain CT scanning in the latter group of patients will either be normal or only show ventricular dilatation due to cerebral atrophy. *Peripheral neuropathies* manifest with painful distal dysesthesias, the etiology of which is not clear. Management of the latter is strictly symptomatic with phenytoin, carbamazepine, or amitriptyline hydrochloride. Close follow-up of hematologic parameters is required in those patients given symptomatic treatment with these drugs. When *cranial neuropathies* occur in AIDS patients, these generally suggest intracerebral lymphoma with meningeal involvement. However, infectious causes such as cryptococcal meningitis should be excluded by appropriate studies of the cerebrospinal fluid. A self-limited aseptic meningitis of unknown etiology may also be responsible for the cranial neuropathy in some patients.

Focal brain lesions in AIDS represent a particularly challenging diagnostic problem. *Toxoplasma* encephalitis is the most common infection presenting in this manner and will most often appear as a single or multiple ring- or diffuse-enhancing lesion on CT brain scan. These involve either the white or gray matter and are associated frequently with a mass effect with edema. The predilection of *Toxoplasma* encephalitis for the deep gray matter (basal ganglia, thalamus, and internal capsule) has been observed. Occasionally, nonenhancing lesions or diffuse encephalitis with normal brain scan may be seen in *Toxoplasma* encephalitis occurring in AIDS patients. Toxoplasma serology usually shows the presence of IgG antibodies with a negative IgM titer consistent with reactivation of an old infection. Although a significantly elevated titer (e.g., over 1 : 1024 dilutions) is often seen, lower or even negative titers of anti-*Toxoplasma* serology may be seen in patients with biopsy proven infection. The therapy of choice against *Toxoplasma* encephalitis is pyrimethamine plus sulfadiazine; the addition of folinic acid is desirable in an attempt to avoid hematologic toxicity. The anti-*Toxoplasma* treatment should probably be continued indefinitely in these patients, in view of the tendency of the infection to recur after therapy.[11] In patients who cannot tolerate the above therapy, clindamycin at a dose of at least 2400 mgs. per day may prove effective.[12] Although biopsy diagnosis is desirable, in those patients where biopsy would be risky, especially those with deep gray matter lesions, empiric anti-*Toxoplasma* therapy may be instituted and response, if any, should occur within 2-4 weeks.

Progressive multifocal leukoencephalopathy (PML) is a demyelinating disorder of viral origin, most cases being due to the J. C. strain of Papova virus. It can present with progressive neurologic dysfunction, with sensory, motor, cerebellar, and speech abnormalities plus progressive dementia. In AIDS, PML occurs less frequently than *Toxoplasma* encephalitis from which it needs to be differentiated. Findings on brain CT scan differ from toxoplasmosis in that lesions occur only in the white matter, they do not enhance with contrast, nor do they produce a mass effect with surrounding edema. Since some of

these patients may respond to cytosine arabinoside,[13] it is felt that biopsy should be obtained when the diagnosis is suspected. On biopsy, the characteristic findings in PML are the eosinophilic intranuclear inclusions in the oligodendrocytes which on electronmicroscopy reveal particles resembling Papova viruses.

Neoplasms of the central nervous system, usually primary lymphoma, occur in AIDS patients and may be seen anywhere in the brain, meninges, or epidural space. The CT scan will characteristically show lesions with diffuse contrast enhancement.

Mycotic Infections

The most common fungal infection in AIDS is oral mucositis (thrush) due to *Candida albicans* infection. This is extremely common and usually recurrent, but generally responds well to nystatin oral suspension or clotrimazole troches. Thrush, however, can occur in patients without cellular immunodeficiency, so it should *not* be considered a finding diagnostic of AIDS in the absence of a major opportunistic infection or Kaposi's sarcoma.

Cryptococcosis is the most common systemic fungal infection in AIDS.

Invasive candidiasis occurs in AIDS patients. Esophagitis is the most common manifestation, and it is a major opportunistic infection in AIDS. The presenting symptoms in *Candida* esophagitis consist of dysphagia and odynophagia; esophageal biopsy will characteristically show tissue invasion with pseudo hyphae. Systemic anti-fungal therapy is required, and most patients seem to respond well to a large dose of ketoconazole (200 mgs. orally twice a day) administered for at least 2 weeks. It is not clear whether a longer administration of anti-fungal treatment is necessary in these patients. Disseminated candidiasis, although not common in AIDS patients, may be seen, and brain abscess may be a complication. Systemic amphotericin B therapy is mandatory in disseminated candidiasis, and at least 6 weeks of treatment are recommended.

Cryptococcosis is the most common systemic fungal infection in AIDS. The most common manifestation is meningitis. Patients will frequently present with a protracted history of headache, neck stiffness, photophobia, and personality changes. While the cerebrospinal fluid will generally show only a few white cells, the india ink preparation will commonly show a large number of encapsulated cryptococci and a high cryptococcal antigen titer (usually over 1:32 dilutions, but often above 1:1024 dilutions). Fungal cultures will generally confirm the diagnosis. Cryptococcal infection outside the central nervous system is common in these patients, and recurrent infection after seemingly adequate therapy can occur. A combined 6-week regime of intravenous amphotericin B plus oral flucytosine is considered optimal for the treatment of cryptococcal meningitis.[14] In view of the heightened potential of hematologic toxicity of flucytosine in the already leukopenic AIDS patient, however, a longer course of amphotericin B therapy alone may be considered. It should be noted that recurrence of infection occurs frequently in these patients, and progressive infection with brain abscess formation may be seen even in those with negative spinal fluid cultures.

Cryptosporidiosis

Cryptosporidium is a protozoan organism existing mainly as a zoonotic infection in a wide range of animals. Infection in man is most likely acquired from an animal source, but it is not clear whether person-to-person spread can occur. The disease in immunocompetent hosts takes the form of a self-limited diarrheal illness, usually less than 4 weeks in duration. Cryptosporidial infection in AIDS is manifested by severe diarrhea, dehydration, progressive weakness and can be fatal. Severe diarrhea with volume loss of 15-20 liters per day has been seen. The diagnosis is generally made through stool examination by Ziehl Nielsen stain, which will show the acid-fast oocysts which measure 4-5 microns in diameter. The Sheather's sucrose flotation technique was originally suggested as the concentration method of choice, but others have found the conventional formalin-ether sedimentation technique used in most parasitology laboratories as an adequate concentration method in cryptosporidiosis.[15] The treatment of cryptosporidiosis in AIDS has been generally unrewarding. The demands for fluid replacement are in some patients quite large and reminiscent of cholera. There is no anti-microbial regimen that will be predictably effective against cryptosporidial infection. However, a recent report suggests that some patients will respond to spiramycin (a macrolide antibiotic, not commercially available in the United States) or to a combination of clindamycin and quinine.[16]

Immunologic Findings

Patients with AIDS have a profound depression of their cellular immune system due specifically to depletion and functional impairment of the T-helper lymphocytes (i.e., T-helper cells). A recently discovered retrovirus, HTLV-III, thought to be the etiologic agent of AIDS and of at least some of the AIDS-related complexes (see section on Etiology), is a lymphocytotrophic agent selectively infecting T-helper cells. This may be responsible for their functional impairment and virtual disappearance from circulation. The main functions of T-helper

cells include: (1) suppression of microorganisms characterized by a latent existence in normal hosts such as a number of viruses, fungi, parasites, mycobacteria, and others; (2) immune surveillance against neoplastic cells; and (3) regulation of B- (or immunoglobulin-producing) lymphocytes. The decreased number and impaired function of T-helper lymphocytes in these patients is manifested clinically by (1) a high incidence of the opportunistic infections discussed earlier, (2) neoplasms, and (3) an unregulated activation of B-lymphocytes, resulting in inappropriate polyclonal elevation of immunoglobulin levels (primarily IgG and IgA), circulating immune complexes, autoimmune phenomena (e.g., ITP), an inordinately high incidence of drug reactions (e.g., sulfa), and possibly impaired serologic response to new or recall antigens.

The much publicized reversal of the T-helper: T-suppressor ratio in AIDS patients is due to a marked decrease in T-helper cells (less than 400 per cubic millimeter, usually much less than 100 per cubic millimeter) with a generally normal number of T-suppressor cells in these patients. *This immunologic profile is by no means specific of AIDS and at no time should a patient be told to have this fatal disease based on an abnormal T-cell study alone, in the absence of serious opportunistic infections or Kaposi's sarcoma.* A markedly inverted helper: suppressor T-lymphocyte ratio to less than 0.5 (normal/1.0) accompanied by a low absolute T-helper cell count (less than 400 per cubic mm.) may signal those patients that should be monitored more closely for opportunistic infections and Kaposi's sarcoma, particularly in the presence of severe fatigue, fever, weight loss, or anemia.

Cutaneous anergy is evident in over 90% of AIDS patients at onset of illness.[1] In the author's own experience, it appeared that the tetanus and diphtheria toxoids, old tuberculin, *Candida albicans,* and trichophytin antigens were the most valuable antigens in delayed cutaneous hypersensitivity testing when screening for cellular immunodeficiency (Multitest, Merieux Institute).

The Chronic Lymphadenopathy Syndrome

Only a few patients with AIDS-related complexes will go on to develop AIDS. The chronic lymphadenopathy syndrome described in homosexual males in the last few years appears to be a form of infection with HTLV-III, the retrovirus recently described as the proposed etiologic agent of AIDS (see section on Etiology). However, only a small proportion of these lymphadenopathy patients (4-17%) have developed AIDS.[17, 18] Findings at the time of diagnosis of lymphadenopathy which are associated with a higher risk of AIDS include a *markedly reduced T-helper lymphocyte count* at less than 400 per cubic mm.; *markedly decreased in-vitro lymphocyte stimulation indices* to mitogens (poke weed, Concanavalin A, phytohemagglutinin) and several microbial antigens; *anemia* (hematocrit less than 40%) and *severe underlying symptoms* (fever, night sweats, extreme fatigue and weight loss). On lymph node biopsy, most patients will show explosive follicular hyperplasia with hyperactive germinal centers. On the other hand, it is felt that the presence of follicular involution on biopsy may be a sign of worse prognosis and that these patients may carry a higher risk of serious opportunistic infections or the neoplastic complications of AIDS than in patients with follicular hyperplasia.[18, 19] However, this histologic pattern is by no means specific.

The level of cellular immunodeficiency in patients with chronic lymphadenopathy is generally less severe than in patients with AIDS. However, the use of corticosteroids (as well as other immunosuppressive agents) is to be discouraged except in life-threatening situations, such as idiopathic thrombocytopenic purpura, because of the possibility of the worsening of the immunosuppressed state and the danger of opportunistic infections.

The Etiology of AIDS

The successful cultivation of human T-cell lymphotropic viruses (HTLV, formerly human T-cell leukemia viruses) in a novel cell propagation system[20] has allowed the identification of one such strain (HTLV-III) as the likely causative agent of AIDS. The HTLV retrovirus may be an etiologic agent of AIDS because (1) it preferentially affects T-helper lymphocytes and may alter their function or result in their destruction, and (2) it can be transmitted through intimate sexual contact or transfusion of blood products. The HTLV-III strain has been recovered in culture from peripheral lymphocytes in 18 of 22 (85%) of homosexual patients with chronic unexplained lymphadenopathy and in 26 of 72 (36%) of patients with AIDS.[21] The lower recovery rate of HTLV-III from AIDS patients may reflect the profound T-helper cell depletion in the peripheral blood of AIDS patients. That HTLV-III infection in humans may exist in an asymptomatic carrier form is suggested by the recovery of this agent from blood of 3 of 4 asymptomatic mothers of juvenile AIDS patients and from 1 of 22 (4.5%) of clinically normal homosexual males.

A summary of the results of antibody prevalence surveys for HTLV-III or LAV (lymphadenopathy virus, also a retrovirus, immunologically and morphologically quite similar, if not identical, to HTLV-III), has been published.[22] A high prevalence of antibody to HTLV-III/LAV has been found among asymptomatic American homosexual men (18-55%), intravenous drug users in New York City

(58-87%), and asymptomatic persons with hemophilia A who had used factor VIII concentrate (72%). As it appears, a specific viral serologic test may not differentiate between AIDS patients, those with ARCs (e.g., lymphadenopathy patients), or asymptomatic carriers of infection. It is anticipated that the diagnosis of AIDS will continue to depend on the satisfaction of strict clinical criteria.

Acknowledgements

The author wishes to thank Drs. J. Hoyt Young, Joseph Hertell, Bruce R. Geer, Robert Lund, David Lowance, and Bess Miller for referring their patients, and Dr. T. J. Spira (Centers for Disease Control) for performing the in-vitro lymphocyte studies in these patients.

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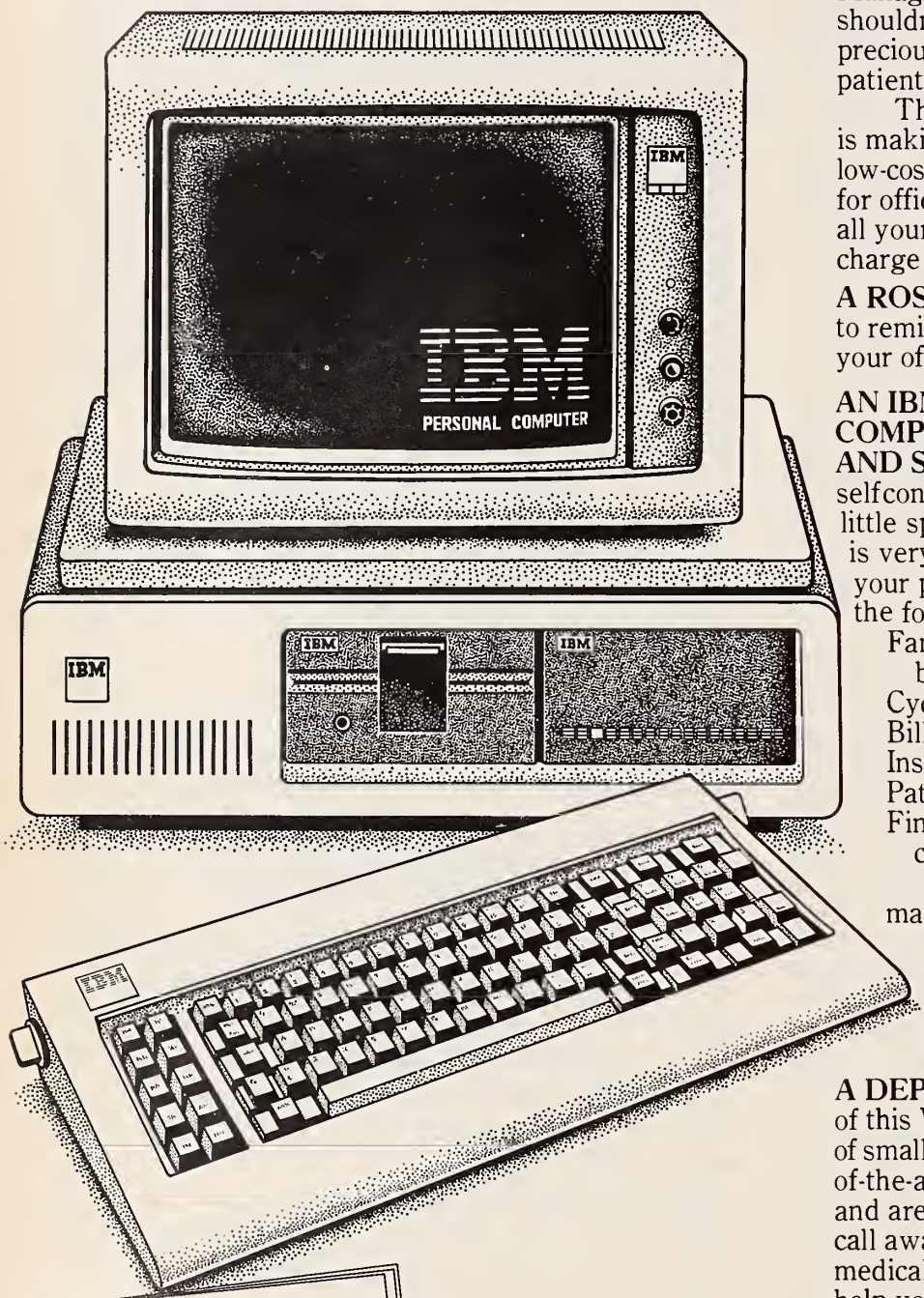
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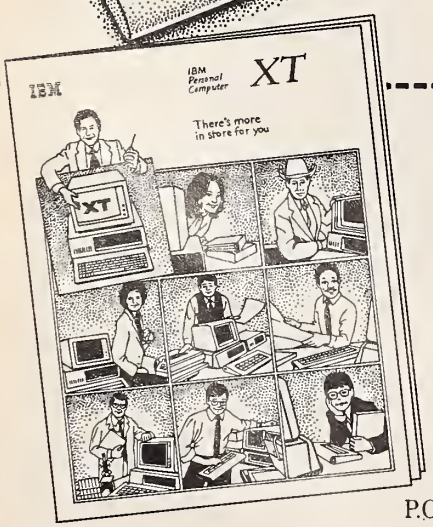
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MANAGEMENT SYSTEMS of WAUSAU

The psychologic and emotional aspects of AIDS can be profound; the authors discuss how physicians and nurses can ease some of the stress associated with caring for these patients.

Psychosocial Issues for People With AIDS

DONALD W. SMITH, Ph.D., and CAITLIN C. RYAN, M.S.W., *Atlanta**

While a diagnosis of acquired immunodeficiency syndrome (AIDS) introduces patient concerns which are typical of other life-threatening illnesses, an AIDS diagnosis presents several considerations which are unique for the patient, their families and friends, and their health care providers:

With an AIDS diagnosis, a patient is automatically associated with a stigmatized population: homosexual, intravenous (IV) drug user, and/or minority member.

Homosexuality is presumed even when the patient may be heterosexual, since approximately 75% of AIDS patients are homosexual men. This can cause an added crisis for the patient's family who may not be aware of his sexual orientation. It can cause anguish for the patient who has not previously disclosed his sexual identity, when he is forced to do so under the specter of a catastrophic illness.

Some family members may blame the patient's lover for their son's condition as well as for his homosexuality. Professional intervention may be required in some situations to help the family cope with two simultaneous crises. Family members, in particular mothers, can sometimes assume responsibility for the patient's condition, feeling that they have contributed in some way to their child's homosexuality or IV drug use. This assumption of guilt can occasionally be made by the patient's lover as well.

Most of the patients with AIDS are young men unaccustomed to serious illness. For them, dependency issues, loss of positive body image, and loss of social supports and income are devastating realities.

* Dr. Smith is a clinical psychologist, and Ms. Ryan is a clinical social worker from Atlanta. Send reprint requests to Dr. Smith at 650 Park Place, Atlanta, GA 30306.

Obtaining a diagnosis of AIDS can often be a lengthy and painful process, since the presence of an opportunistic infection or Kaposi's Sarcoma (K.S.) is required for a case definition of AIDS as set forth by the U.S. Public Health Service's Centers for Disease Control (CDC). Some individuals can experience uncomfortable, vague symptoms for months or years, such as night sweats, fatigue, swollen lymph nodes, weight loss, etc., before an opportunistic infection or K.S. become evident. The level of anxiety prior to a confirmed diagnosis of AIDS can be profound.

Subsequently, patients with an AIDS-related complex (ARC) who possess any combination of the vague symptoms previously mentioned can live in a twilight of uncertainty as to whether they may or may not develop AIDS. The connection between ARCs, or what is incorrectly referred to as pre-AIDS, and AIDS itself is still unclear.

Dramatic changes in normal social interaction occur for people with AIDS. Friends and lovers can abandon them upon learning of their diagnosis. Some lose their jobs and homes or are forced to vacate their apartments because of fear of contagion.

While routine social contact does not transmit AIDS, people with AIDS, their spouses/lovers, and others at high risk for AIDS need to be informed about lower risk sexual behaviors, such as mutual masturbation and use of condoms. Sensitivity to their need for human contact is required on the part of practitioners. A reduction in the number of anonymous or multiple sexual partners is viewed as the most important factor in reducing risk for AIDS. Many lovers of people with AIDS have not contracted AIDS, just as family members who care for patients at home have not developed AIDS.

Guilt and shame are common reactions to obtaining a diagnosis of AIDS. Many people with AIDS will try to ascertain a possible "reason" for their illness. It is not unusual for a person with AIDS who is homosexual to respond to his diagnosis with a reactivation of the negative social and cultural messages surrounding homosexuality. AIDS may then be interpreted as a divine punishment for homosexual orientation. Pastoral counseling with a sensitive and knowledgeable clergy member can help reduce these guilt feelings.

The potential support available to the patient from his family and friends is an important adjunct to treatment. Homosexual people are often estranged from their biologic family because of negative responses to their homosexuality, either actual or anticipated. As a result, the "homosexual family" (which is comprised of the individual's homosexual support system) often assumes equal or greater importance as a social support. Their involvement in the patient's treatment and hospitalization, including visitation privileges, is often crucial to the patient's emotional well being.

Since homosexual relationships, regardless of duration, are not legally sanctioned, little recognition or empathy is available to lovers of people with AIDS. Though they may financially and emotionally support their lover during the course of his illness and death, except in the rarest of instances, they are not permitted to plan and carry out their lover's funeral services. Some are barred from the funeral by members of their lovers' biologic family. As much as possible, these individuals should be accorded the rights and privileges of family members in hospital settings and included in discussions of treatment plans and discharge planning.

Many health care professionals are still uncomfortable about providing services to AIDS patients. Some carry out excessive and unnecessary infection control practices which further isolate the patient. Some refuse treatment or provide abrupt and inadequate treatment, exacerbating the patient's sense of loss and rejection.

Open discussion among staff members, allowing them to ventilate their fears and concerns, is helpful in reducing the level of staff anxiety about working with an AIDS patient. The intervention of an infection control practitioner can provide appropriate information to dispel myths and fears. No hospital worker, not in a high risk group, has contracted AIDS through normal provision of services.

People with AIDS have asked, whenever possible, that homosexual staff members or practitioners identify themselves to the patient, thereby reducing their sense of fear and isolation. People with AIDS in rural settings who have limited support can benefit greatly from sharing with other people with AIDS, especially through AIDS organizations providing outreach to isolated individuals.

The response to the AIDS crisis from the private sector has been unprecedented in the history of epidemics. Full social service agencies have evolved in cities all around the country. One such organization, AID Atlanta, the largest southeastern AIDS organization, is a non-profit service organization comprised of volunteers, health professionals, members of the general public, and community leaders who provide direct services to people with AIDS, assistance to health care providers, and information to the public. These services are free.

The following support and education services are available:

Hotline — Providing crisis intervention, referrals, and information on AIDS.

Buddies — Trained volunteers who are available to provide support and companionship to people with AIDS.

People With AIDS Support Group — An informal social outlet and support network.

Social Service Advocacy — Education to social service departments of hospitals and agencies working with AIDS patients, and assistance to people with AIDS and their families in obtaining appropriate services.

Legal Counseling — Assistance in protecting personal rights, arranging for power of attorney, drafting wills.

Crisis Intervention — For immediate and short-term psychologic counseling.

Religious Support — From clergy members representing the major denominations.

Emergency Assistance Fund — Limited, immediate financial assistance for emergency nonmedical expenses.

Referrals — To knowledgeable professionals throughout the Southeast.

Professional Education — Providing speakers and in-service training to hospitals, agencies, and organizations.

Printed Materials — Including risk reduction brochures, psychosocial information, infection control guidelines, etc.

To obtain additional information on services available, call or write: AID Atlanta, 1801 Piedmont Road, NE, Atlanta, GA 30324; (404) 872-0600.

Epidemiologic and laboratory observations strongly suggest AIDS is caused by an infectious agent, most likely a retrovirus, alone or in combination with other factors.

Acquired Immunodeficiency Syndrome (AIDS): An Epidemiologic and Clinical Overview

KENNETH G. CASTRO, M.D., and ANN M. HARDY, Dr. P.H., *Atlanta**

Abstract

The acquired immunodeficiency syndrome (AIDS) is a recently recognized disease characterized by a depression in cell-mediated immunity. As of May 14, 1984, a total of 4,431 cases of AIDS had been diagnosed in the United States; 56 of these cases were in Georgia. The average case-fatality ratio for AIDS is 43%. Over 85% of the cases are in either homosexual/bisexual men or intravenous drug abusers. Patients with AIDS are susceptible to a variety of opportunistic diseases, the two most common of which are *Pneumocystis carinii* pneumonia and Kaposi's sarcoma. Although specific therapy for most of the opportunistic diseases is available, treatment to correct the underlying immunologic defect is still lacking. If the Public Health Service guidelines are followed, the risk of disease transmission should be minimal.

Introduction

ACQUIRED IMMUNODEFICIENCY SYNDROME (AIDS) was first recognized in the spring of 1981 when the Centers for Disease Control in Atlanta received reports of multiple cases of two rare diseases, *Pneumocystis carinii* pneumonia (PCP) and Kaposi's sarcoma (KS), occurring in young, previously healthy homosexual men from New York City and California.[1, 2] All of these cases had similar patterns of underlying immunosuppression without any apparent cause. Shortly after receiving these reports, CDC began to study this apparently new syndrome. This report will summarize the epidemiologic and clinical features of AIDS.

Epidemiology of AIDS

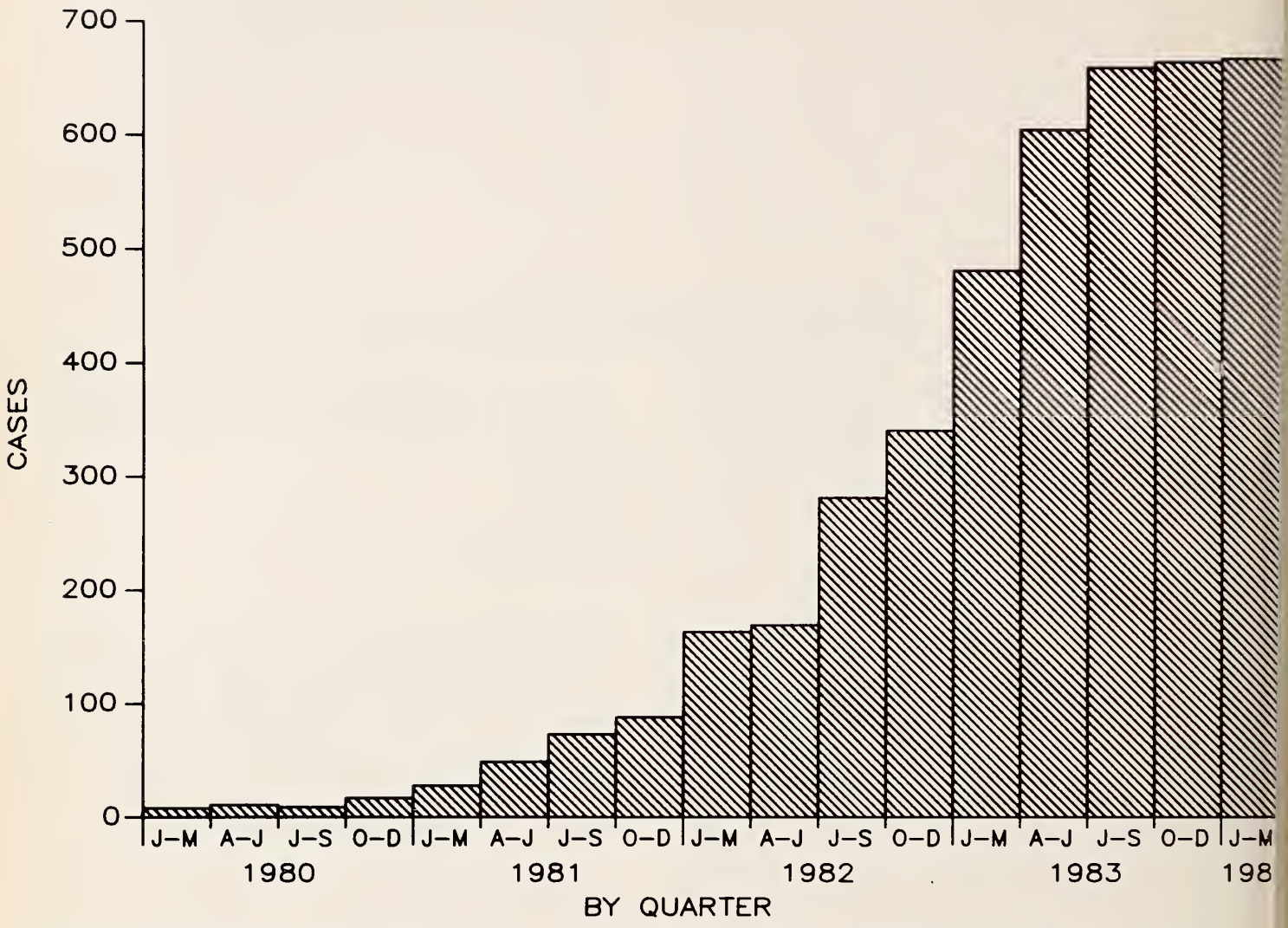
An early observation was that patients with AIDS had a specific impairment in the cell-mediated component of the immune system and developed diseases predictive of this impairment.[3-5] This observation was used to formulate a surveillance case definition. *A case of AIDS is defined as a reliably diagnosed disease that is at least moderately predictive of underlying cellular immune deficiency in a person with no known underlying cause of cellular immune deficiency or any other cause of reduced resistance reported to be associated with that disease.*[6] Ten opportunistic diseases currently are considered to be indicative of AIDS (Table 1).

At present, cases of AIDS are reported by clinicians to state or local health departments who in turn channel the reports to CDC. In certain areas, such as New York City, health officials actively seek new cases by routinely contacting hospitals in their area. CDC also reviews requests for pentamidine isethionate used to treat *Pneumocystis carinii* pneumonia (PCP) to identify additional AIDS patients; CDC is the sole source of this drug in the United States.

As of May 14, 1984, a total of 4,431 cases of AIDS meeting the case definition had been reported in the United States (4135 cases occurred in males, 296 in females). Figure 1 shows the epidemic curve

* AIDS Activity, Center for Infectious Diseases, Centers for Disease Control, Public Health Service, U.S. Department of Health and Human Services, Atlanta, GA 30333. Send reprint requests to Dr. Castro.

FIG. 1 ACQUIRED IMMUNODEFICIENCY SYNDROME (AIDS) CASES, BY QUARTER OF DIAGNOSIS, UNITED STATES, 1980—MARCH 1984*



*EXCLUDES CASES DIAGNOSED BEFORE 1980 AND CASES FOR WHICH DATE OF DIAGNOSIS WAS NOT REPORTED

of the outbreak by quarter of diagnosis through the first quarter of 1984. In retrospect, the first cases of AIDS were diagnosed in 1978. The number of cases in the first quarter of 1984 is still likely to increase due to the lag between the diagnosis of AIDS and the report of the case to CDC.

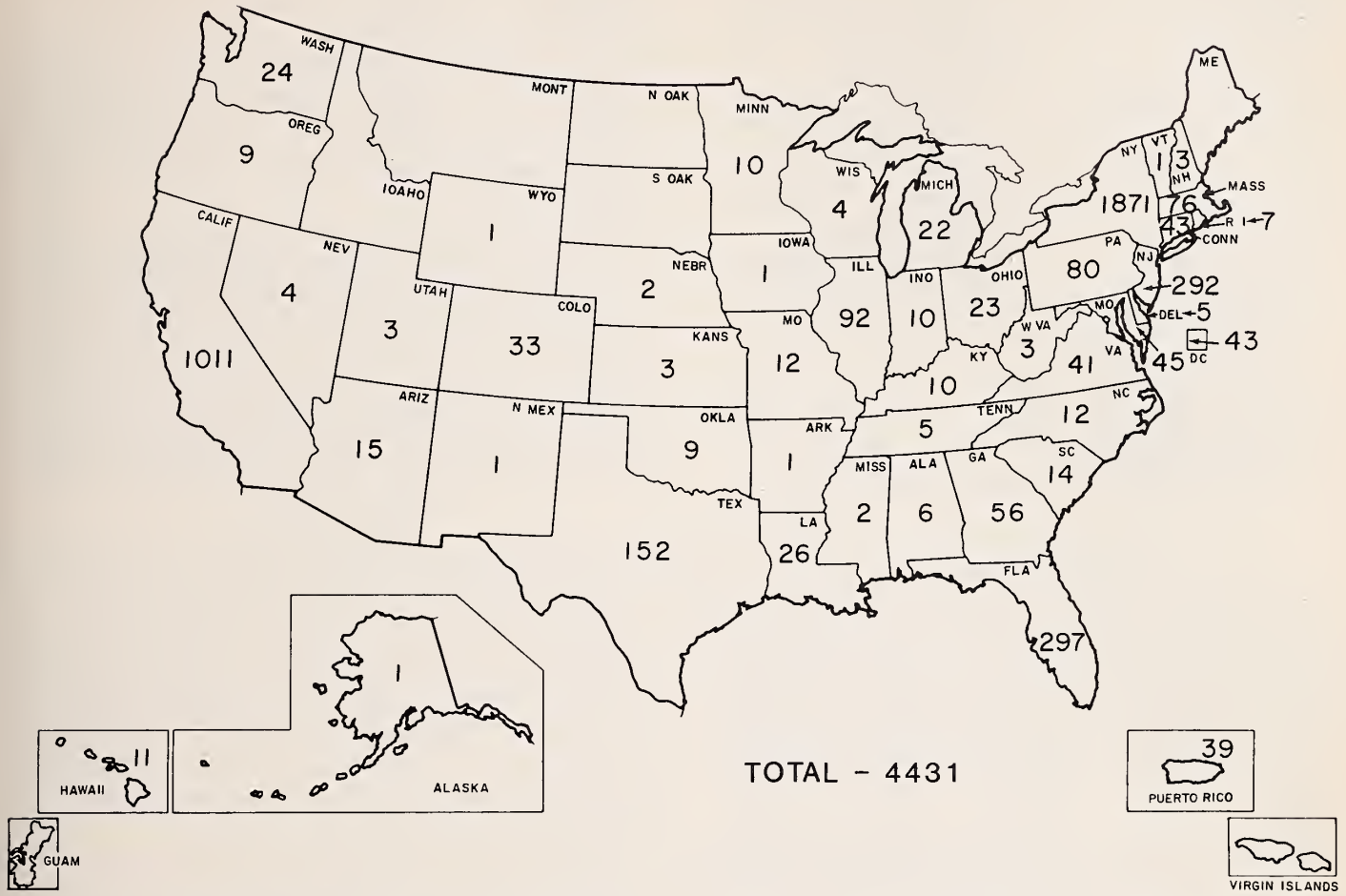
Forty-two percent of AIDS cases have been reported from New York (Figure 2). Most of these patients are residents of New York City. California (primarily San Francisco and Los Angeles) accounts for 23% of the cases. Other states with more than 100 cases include Florida (297 cases), New Jersey (292 cases) and Texas (152 cases).

Cases of AIDS can be divided into five patient categories (Table 2). These categories are hierarchically arranged so that each patient falls into only one category. The majority of AIDS patients (71.9%) are homosexual/bisexual men. Past or present abusers of intravenous (IV) drugs compose 17.5% of the total. More than half the women with AIDS are IV drug abusers. Four percent of patients are Haitian entrants to the United States, and about 1% are hemophiliacs. Six percent of the patients do not fit into any of these categories; included in this group are 43 patients who received blood transfusions in the 5 years prior to diagnosis and 35 heterosexual contacts of persons in one of the first four categories.

About half of the patients with AIDS have developed *Pneumocystis carinii* pneumonia (PCP), one-fourth have had Kaposi's sarcoma (KS), 7% have had both PCP and KS, and 17% have had another opportunistic infection (Table 3). The distribution of diseases varies by patient category. Homosexual/bisexual men are more likely to have KS than the other groups. PCP is more common among IV drug users and hemophiliacs. Haitians have a higher proportion of patients with other opportunistic infections.

The age distribution of AIDS patients has remained relatively constant over time. Over 90%

Fig. 2 ACQUIRED IMMUNODEFICIENCY SYNDROME (AIDS) CASES REPORTED TO CDC, BY STATE, UNITED STATES, AS OF MAY 14, 1983



have been between the ages of 20 and 49; 47% are in the 30-39 age group. This observation is of interest because other sexually transmitted diseases generally occur in slightly younger individuals.

Three of the major racial/ethnic groups are represented: 58% are white, 25% are black, and 14% are Hispanic. The number of Asians is strikingly low, even though New York City and San Francisco have large Asian populations.

The overall reported case-fatality ratio for AIDS is currently 43%. Risk of death varies both by disease group and by time from diagnosis of AIDS. Patients with KS alone have a lower fatality rate (24%) than those in other disease groups (48 to 65%). The rate increases as time from diagnosis of AIDS increases. For patients with AIDS diagnosed prior to 1982, the case-fatality ratio is 82%; 62% with AIDS diagnosed in 1982 have died, and 38% of those with AIDS diagnosed in 1983 have died.

In addition to the 4431 cases described above, CDC has received reports of 56 children (30 male, 26 female) under the age of 5 years who meet a provisional case definition for pediatric AIDS.[7] The case definition for children is equivalent to that used for adults except that congenital infections (e.g., herpes simplex virus infection and toxoplasmosis in the first month and cytomegalovirus infection in the first 6 months after birth) are excluded, and primary immunodeficiency diseases must be ruled out. All of these children have had opportunistic infections; 3 also have had KS. Thirty-seven (67%) are known to have died.

Three of these children had a parent (2 mothers, one father) with AIDS. Thirty-three had at least one parent who did not have AIDS but was a member of a group at increased risk for AIDS. Eleven of the remaining 20 children had received transfusions with blood or blood components before the onset of AIDS. One of these transfusion recipients received platelets from a man who later died of AIDS.[8]

AIDS in Georgia

As of May 14, 1984, 56 cases of AIDS had been reported in Georgia. Thirty (53%) of these patients have died. Forty-two (75%) are from Atlanta, making it the 12th ranking metropolitan area in the nation in the number of AIDS cases. The distribution of the Georgia cases by patient characteristic is similar to that for all of the United States cases. Fifty (89%) are either homosexual/bisexual men or IV drug users. Sixteen percent had KS without PCP, 60% had PCP alone, 2% had both KS and PCP, and 21% had other opportunistic infections.

Table 1 — Diseases Considered to be Indicative of AIDS

Protozoal Infections	Fungal Infections
Pneumocystis carinii pneumonia	*Candida* esophagitis
Toxoplasma gondii encephalitis or disseminated infection (excluding congenital infection)	*Cryptococcal* meningitis or disseminated infection
Chronic (>1 month) *Cryptosporidium* enteritis	Bacterial Infection
Non-Congenital	Disseminated (not just pulmonary or lymphatic) *Mycobacterium avium-intracellulare*
Viral Infections	Cancers
Chronic (>1 month) mucocutaneous herpes simplex	Kaposi's sarcoma (in a person under age 60)
Histologically evident cytomegalovirus infection of an organ other than liver or lymph node	Primary brain lymphoma (limited to the brain)
Progressive multifocal leukoencephalopathy	

Clinical Aspects

The salient feature of patients with AIDS is a deficiency in the T-lymphocyte arm of the immune system. Opportunistic infections and opportunistic malignancies, common to patients who are immunosuppressed because of lymphoreticular neoplasms or cytotoxic therapy, are the primary manifestations of AIDS.

Pneumocystis carinii pneumonia (PCP) is the most frequently encountered infection.[6] Patients commonly give a history of fever, fatigue, nonproductive cough, and mild-to-severe dyspnea. Clinical and laboratory findings include cyanosis, diffuse moist rales and rhonchi, and varying degrees of hypoxemia.[3, 4, 9] Findings on chest x-ray range from normal to diffuse bilateral pulmonary interstitial and alveolar infiltrates. Diagnosis is established by identification of *Pneumocystis carinii* in bronchial washings or in lung tissue obtained through transbronchial or open lung biopsy.[9] Trimethoprim-sulfamethoxazole (TMP/SMX) is the initial treatment of choice.[9, 10] However, this drug has been associated with a high frequency of adverse effects in AIDS patients.[4, 10] Patients who do not respond to or cannot tolerate TMP/SMZ should be given pentamidine isethionate. This drug is available from CDC Drug Service (Telephone 404-329-3670).

Table 4 lists the opportunistic organisms that have been described in AIDS patients; their clinical manifestations and therapies have also been tabulated. Clinicians should be aware that coexisting serious opportunistic infections in many of these patients have been reported.[3, 4, 6]

Two opportunistic malignancies described in AIDS are Kaposi's sarcoma (KS) and B-cell lymphoma of the central nervous system.[16, 17] In its classic form, KS is a rare, indolent disease affecting mostly elderly white males.[18] In contrast, KS seen in AIDS patients has a more aggressive clinical course. Patients most commonly present with dark-blue or purple-brown cutaneous plaques or nodules in the extremities and/or mucosal surfaces. Lymph node and visceral involvement has also been commonly reported.[19, 20] Classic KS has been successfully treated with chemotherapy.[21, 22] Experimental trials for management of KS in AIDS patients are in progress.[23, 24]

At present there are no laboratory tests that are completely specific for diagnosing AIDS; however, the following laboratory abnormalities are commonly observed in AIDS patients: absolute lymphopenia, skin-test anergy, and a reversed ratio of T-helper to T-suppressor lymphocytes. If used for patients with clinical features suggestive of AIDS, these tests may prove to be useful diagnostic tools.

AIDS Spectrum

Several other conditions may also be part of the clinical spectrum of AIDS. Physicians from New York, San Francisco, Atlanta, and other major metropolitan areas in the United States have reported seeing homosexual men with chronic, unexplained, generalized lymphadenopathy.[25, 26] Some of these patients have evidence of cellular immune dysfunction, and a small proportion have developed KS or opportunistic infections.[27]

Additionally, several unusual diseases have recently been reported with increased frequency in homosexual men: diffuse undifferentiated non-Hodgkin's lymphoma,[28] squamous cell carcinoma of the oral cavity and tongue,[29, 30] and autoimmune thrombocytopenic purpura.[31]

We believe that the concurrent increase of lymphadenopathy and at least some of the rare malignancies in patients with characteristics similar to AIDS patients are indeed associated and not merely coincidental. As such, they may represent different aspects of the full spectrum of AIDS.

Other investigators have also described an increased frequency of immunologic abnormalities in relatively healthy homosexual men and hemophiliacs.[32-34] The natural history of this "subclinical state of immunosuppression" remains unknown. Whether or not these immunologic alterations are part of the AIDS spectrum is unclear.

Conclusions and Recommendations

Epidemiologic data indicate that AIDS is a new and very serious disease. It primarily affects young adults living in one of several major metropolitan areas. The majority of patients are homosexual men, but heterosexual men and women have also been affected. Those heterosexual men and women who are intravenous drug users, recent Haitian immigrants, hemophiliacs, or sex partners of AIDS pa-

Table 3 — Reported AIDS Cases and Case-Fatality Ratio, By Disease Category, As of May 14, 1984

*Primary Disease**	*Cases*	*Percent of Total*	*Deaths*	*Case Fatality Ratio*
KS without PCP	1109	25.0	272	24.5
PCP without KS	2290	51.7	1086	47.4
Both KS and PCP	289	6.5	187	64.7
OI without KS or PCP	743	16.8	388	52.2
TOTAL	4431	100.0	1933	43.6

* KS = Kaposi's sarcoma
PCP = *Pneumocystis carinii* pneumonia
OI = other opportunistic infections

tients appear to be at increased risk of developing the disease.

Epidemiologic and laboratory observations strongly suggest AIDS is caused by an infectious agent, most likely a retrovirus, alone or in combination with other factors. It appears to be transmitted through intimate sexual contact or through parenteral contact with blood or blood-products. It also appears likely that this putative agent produces a spectrum of disease ranging from subclinical to fatal.

Based on current knowledge and the apparent similarity of AIDS transmission to that of hepatitis B virus, the U.S. Public Health Service has issued specific recommendations for preventing AIDS transmission:[35]

1) Sexual contact should be avoided with persons known or suspected to have AIDS. Multiple sexual partners may increase the probability of contracting AIDS.
2) As a temporary measure, members of groups at increased risk for AIDS should voluntarily refrain from donating plasma and/or blood.

Table 2 — Reported Cases of AIDS, by Patient Characteristic, As of May 14, 1984

	Males		*Females*		*Total*	
*Patient Characteristics**	*Cases*	*Percent*	*Cases*	*Percent*	*Cases*	*Percent*
Homosexual or bisexual	3185	77.0	0	0.0	3185	71.9
Intravenous (IV) drug user	609	14.7	165	55.7	774	17.5
Haitian	149	3.6	27	9.1	176	4.0
Hemophiliac	31	0.7	0	0.0	31	0.7
None apparent/unknown	161	3.9	104	35.1	265	6.0
Total	4135	100.0	296	100.0	4431	100.0

* Patient characteristics listed are ordered hierarchically; cases with multiple characteristics are tabulated only in the group listed first.

Table 4 — Summary of Opportunistic Infections Seen in AIDS Patients, Clinical Manifestations and Treatment

Organism	*Clinical Manifestations*	*Therapy*
Cytomegalovirus (CMV)	—severe bilateral pneumonia (often with *P. carinii*) —chorioretinitis —encephalitis —hepatitis —enterocolitis —disseminated infection	FIAC,* high dose ara A* Other regimens under investigation[11, 12]
Herpes simplex virus (HSV)	—chronic mucocutaneous (perianal and perioral) ulceration —disseminated infection	acyclovir,† FIAC,* ara A*[11, 12]
Papovavirus or J-C virus resulting in progressive multifocal leukoencephalopathy (PML)	—multifocal neurologic deficits —dementia	Ara C*[11, 12]
Candida albicans	—esophagitis —disseminated infection	Nystatin, Ketoconazole[12]
Cryptococcus neoformans	—meningitis	Amphotericin B† (also with 5-Fluorocytosine)[12]
Pneumocystis carinii	—diffuse pneumonitis	TMP/SMZ,† Pentamidine isethionate[9, 10]
Toxoplasma gondii	—chorioretinitis —encephalitis	Sulfadiazine plus Pyrimethamine†[13]
Cryptosporidium sp.	—enteritis	Clindamycin plus quinine, Spiramycin.*[14, 37]
Mycobacterium avium-intracellulare	—diffuse pneumonitis —disseminated infection	INH, Rifampin, Ethambutol, and Streptomycin, Clofazamine,* Ansamycin*[15]

Abbreviations: *FIAC* = 2-fluoro-5-iodo-beta-D-arabinofuranoscylcytosine. *Ara A* = Adenosine arabinoside. *Ara C* = Cytosine arabinoside. *TMP/SMZ* = Trimethoprim sulfamethoxazole.
* Experimental therapy.
† Treatment of choice.

3) Physicians should adhere strictly to medical indications for transfusions, and autologous blood transfusions are encouraged.
4) Work should continue toward development of safer blood products for use by hemophiliac patients.

Although specific therapy for most of the opportunistic diseases is available, treatment to correct the underlying immunologic defect is still lacking.

For clinical and laboratory staffs providing care for AIDS patients, the following precautions have been recommended:[36]

1) Extraordinary care must be taken to avoid accidental wounds from sharp instruments contaminated with potentially infectious material and to avoid contact of open skin lesions with material from AIDS patients. Needles should not be bent after use but should promptly be placed in a puncture-proof container used solely for disposal.
2) Gloves should be worn when handling blood specimens, body fluids, secretions, and excretions, as well as surfaces and objects exposed to them.
3) Gowns should be worn when clothing may be soiled with body fluids or blood.
4) Blood and other specimens should be labeled prominently to alert laboratory workers to the potential hazard. All specimens should be placed in a second container for transport.
5) Blood spills should be cleaned promptly with a disinfectant solution, such as 5.25% sodium hypochlorite (household bleach) in a 1 : 10 dilution with water.
6) Disposable items should be placed in plastic bags and incinerated or disposed of in accordance with the hospital's policies for disposal of infectious wastes. Reusable items should be sterilized whenever possible.

Since continued monitoring of the epidemic and further understanding of the disease depend on cooperation between clinicians, epidemiologists, and other public health personnel, Georgia physicians and other health-care providers should report cases of AIDS to the Georgia Department of Human Resources, Division of Physical Health (telephone 404-656-4764), which will report these to CDC.

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The author describes how one doctor uses some of his leisure time in a creative, adventuresome way.

Hiking: A Change of Pace From the Pressures of Medical Practice

EVELYN WARD GAY, *Decatur**

"He who is indeed of the brotherhood of walkers, does not voyage in quest of the picturesque — but of the hope and spirit with which the march begins at morning and the peace and spiritual repletion of the evening's rest. He cannot tell whether he puts his knapsack on or takes it off with more delight."

THAT WAS Robert Louis Stevenson speaking, but the words easily could have come from Dr. Morton P. Berenson, of Columbus. Dr. Berenson, a specialist in internal medicine and hematology, is a long-distance hiker who has been exploring remote trails for many years. He has covered wide areas in several parts of the country, and in 1983 succeeded in reaching the highest point in the original 48 states — the top of Mt. Whitney.

Dr. Berenson began hiking in the Pacific Northwest when he was a Boy Scout at about the age of 12. Born in Washington State and reared in Oregon, the grandson of Russian immigrants with the name Brezhn who had come to America in 1901, he had made pilgrimages through the Cascade Range, including Mt. Olympus, Mt. Ranier, and Mt. Hood, by the time he was 22 years of age.

But after graduating from the University of Oregon with a degree in mathematics, and entering medical school at Stanford University in California, his hiking days had to be suspended, he says, until a later date. Between 1958 and 1972, he did no hiking at all. During those years, he was busy getting his M.D. degree, doing further work at the University of Chicago and at Stanford University, spending 2 years in the Army with service in a medical detachment at Fort Benning near Columbus and in Saigon, and completing his specialty training at the Medical College of Georgia in Augusta.



Dr. and Mrs. Morton P. Berenson, of Columbus, are shown with one of their four sons at their home.

While in the Army at Columbus, he married a Columbus girl, and they eventually became the parents of four sons. They now have one grandchild. In 1968, he began his medical practice in Columbus. The call of the trail beckoned again in 1972, however, and he took up his long-neglected love of hiking, which by that time involved his family as well. They began by buying a camper and going to Amicalola Falls in North Georgia where they met friends and set out to hike along the Georgia section of the Appalachian Trail, covering about 80 miles and

* Mrs. Gay is Chairman of the Research and Romance of Medicine Committee of the Auxiliary of the MAG. Her address is 911 Vistavia Circle, Decatur, GA 30033.

reaching the North Carolina line. The next year they hiked through the Smokies of North Carolina for about 150 miles more.

The Appalachian Trail, now in its 60th year of attracting hikers and nature lovers, begins at Springer Mountain in North Georgia and can be followed to its end at Mt. Karahdin in Central Maine. It touches or traverses 14 states and is between 2000 and 2100 miles in length, explains Dr. Berenson. A footpath marked throughout by white blazes painted on trees, it is the longest continuous hiking trail in the world. It reaches its highest point at Clingman's Dome in the Great Smoky Mountains of Tennessee (6,643 feet) and its lowest where it crosses the Hudson River in New York, at which point it approaches sea level.

Dr. Berenson describes the Appalachian Trail as being "remote for contemplation, lonely for solitude, narrow for chosen company, and winding for leisure," and declares that hiking it is a "delightful change of pace from the pressures of medical practice." Among the pleasures he enjoys on the trail are the opportunities it gives to commune with nature, the variety of wild flowers such as flame azaleas, mountain laurel, and rhododendron, as well as the challenge it offers to one's physical stamina.

However, Dr. Berenson says that hiking requires no special training, although he tries to keep in shape by running in his neighborhood several days a week. His main suggestion for anyone beginning a hike is that he buy "a good pair of hiking boots" and break them in "on Pine Mountain Trail which is a 24-mile footpath in Franklin D. Roosevelt State Park." This trail, he says, can be done in an overnight hike and has many scenic areas. Gear, including a tent, can be carried in a backpack.

Dr. Berenson describes the Appalachian Trail as being "remote for contemplation, lonely for solitude, narrow for chosen company, and winding for leisure."

Supplies for longer trips should include plenty of freeze-dried food which can be added to water, hot or cold, to make it palatable. His choices include beef and rice, chicken and rice, or macaroni and cheese. Water can be obtained from mountain streams (or from glacier melts at high altitudes in some parts of the country) and heated on a propane gas stove which is carried in a backpack. Dr. Berenson says that he has never had trouble with water, which often is pure enough to use without boiling if there are no livestock in the vicinity.

Each year, the Berenson family, in varying size groups which sometimes include friends, has added 120 to 130 miles to their trek along the Appalachian Trail, to finally reach the Maryland-Pennsylvania line, which is also the site of the original Mason and Dixon's Line. This means that by taking up the trail each year where they left off the previous year, they have to date covered about 1000 miles, half the length of the trail, in 10 years.

The Appalachian Trail, Dr. Berenson explains, offers sections which lend themselves to pleasant 1-day hikes for some families. For those who wish to complete the entire trail, he says there are different ways to accomplish this. He prefers 7- to 10-day hikes, usually in the springtime. Some people, however, take as long as 4 or 5 months and cover the entire trail in one season.

The Appalachian Trail, now in its 60th year, offers sections which lend themselves to pleasant 1-day hikes for some families.

A tent is a necessity on the Appalachian Trail, he says, because all sections are not equipped with shelters, and times for stopping are not always predictable. Many areas, however, do furnish shelters, such as youth hostels, or there may be some free or inexpensive lodges along the way. And there can be many surprises along the trail. The Berenson family has encountered hot and cold weather, sleet and rain, and the tail end of Hurricane Agnes when 8 inches of rain fell in 1 day and winds reached 30 to 40 miles an hour.

One time they had to get off the trail in Virginia because of bad blisters and other foot problems. Usually, they make sure that they take along two cars and have one parked at the place they plan to end their hike, but this time they had to hitchhike to reach their car.

In the Smokies, they have seen black bears and many deer on the trail, but these animals have caused no major problems. Some of their greatest pleasures, Dr. Berenson says, have come from meeting other people along the way. They come from all over — some from as far away as Canada and Australia. And what he calls "a communications network" is always in operation. It is possible for one to obtain many bits of important information regarding the weather or the terrain from people who have just come through the area he is entering.

In the late summer of 1983, Dr. Berenson and one of his sons returned to the Pacific Northwest where they hiked a section of the Pacific Crest Trail, which runs from the Mexico-California border through California, Oregon, and Washington, at the crest of the Sierra Nevada to the Canadian border, for a distance of 2700 miles. This trail, however, is not continuous, explains Dr. Berenson, and there are

(Continued on p. 551)

The implications of an increased supply of physicians are diverse and complex.

The Coming Abundance of Physicians — The National Outlook

PAUL M. SCHWAB, ***Rockville, Maryland****

SPEAKING TO THE AMA Medical Student Section recently, Dr. Robert Graham, Administrator of the Health Resources and Services Administration, provided a perspective for the coming years.[1] He predicted that some graduates of U.S. medical schools will find themselves without first-year training positions within the next 5 years; that at least 10 medical schools, both private and public, will discuss closing their doors and almost all within 5 years will discuss reducing class size by 5 to 50 percent; large organizations — HMOs, corporations, medical school faculty practice groups, and preferred provider organizations — will dominate the practice of medicine; delivery systems will be vertically and horizontally integrated; more competition will occur among institutional providers over who can deliver the most generous benefit package; in competing, primary care physicians will extend their office hours, make house calls, and adopt other marketing practices; and specialists may find themselves cultivating primary care physicians for referrals.

About 20 years ago, this country embarked on a campaign to overcome a serious shortage of health care personnel — including but not limited to physicians. Under the impetus of federal as well as state funding, there was an unprecedented expansion of health professions training facilities. Growth in the supply of providers was also remarkable. The supply of active physicians (MDs and DOs), for example, grew from just under 325,000 in 1970 to 467,000 in 1981 — an increase of 44 percent. During that same period, the physician ratio increased nationally from 151 per 100,000 population, to over 200.

Despite these large increases, however, the specialty composition of physicians did not change significantly. In the primary care category as a whole — usually viewed as consisting of general and family practice, internal medicine, and pediatrics — the number grew significantly but their overall percentage relative to all physicians remained relatively constant. The surgical specialties represented the largest group of specialties in 1975 (28 percent) but were surpassed by medical specialties in 1981 (30 percent).

Given the current national attention to prevention, it is important to note that the only specialty areas which experienced substantial decreases during the past decades were the preventive medicine specialties — with an overall decline from 3.7 physicians in 1970 to 2.7 physicians per 100,000 population in 1981.

Overall, some change occurred in the geographic distribution of our nation's physicians. For example, in the most isolated areas — that group of counties that lack any urban population — the long-run decline in the supply of physicians halted, and the supply began to grow. It actually rose at a faster rate than the national average near the end of the 1970's decade. The number of counties with no MDs and with very low MD-to-population ratios dropped. Also, a number of states whose ratios earlier had been substantially below average experienced faster growth in physician supply than the U.S. average. In fact, the number of states whose ratio was more than one-fifth below the national average was reduced by 25 percent.

* Mr. Schwab is Associate Administrator for Policy Coordination, Health Resources and Services Administration, Public Health Service, U.S. Department of Health and Human Services, Room 14-05, Parklawn Building, 5600 Fishers Lane, Rockville, MD 20857. This is an edited version of his paper presented at MAG's Leadership Conference Saturday afternoon program, "Training Future Physicians for the Competitive Medical Marketplace," in January 1984.

Although these recent developments are meaningful, their real significance may rest with future considerations and their role in evaluating the matter of physician abundance. The number of active physicians is expected to show a steady increase. Many of those physicians who will enter the profession during the 1980s are already in the educational pipeline and clearly will enter the profession when they graduate.

Although medical school enrollment has shown sharp increases over the past 2 decades, in the last 7 years the rate of growth has tapered off considerably, with total enrollment up only about 2 percent last year and by less than 1 percent this past fall. Enrollment of new entrants to medical schools decreased slightly the last 2 years (by 77 to 16,567 and 87 to 16,480), the first declines registered since 1965. Although predictions vary on future levels, many observers anticipate modest decreases over the next few years rather than a dramatic return to the enrollment levels of the early 1970s.

We expect the number of active physicians to exceed 700,000 by the year 2000, or half again as many as there are today. Even if enrollments drop and the number of foreign-trained physicians entering the U.S. should be restricted further, the supply in the year 2000 would only be slightly less than this. Sixteen years from now, the current national ratio is likely to increase to 264 per 100,000.[2]

The expanding supply of physicians may affect measures of access other than just the geographic distribution of available services.

Clearly these are tremendous increases in the supply of physicians. However, are we talking about an abundance or an overabundance in the years ahead? A number of approaches have been undertaken to address this question quantitatively.

The Federal Bureau of Health Professions has developed requirements projections based upon assumptions concerning expected changes in population composition and size, projected economic growth, insurance trends, and productivity developments.[3] The Bureau's estimate is that demand-based requirements for physicians will be about 655,000 in the year 2000. For 1990, an excess of 35,000 physicians is projected; this figure increases to nearly 52,000 in 2000, or 7 percent of the total supply.

These requirements estimates and the resulting national supply/requirements relationship in the year 2000 differ significantly from those developed by GMENAC, the Graduate Medical Education National Advisory Committee. The major findings of GMENAC were that: (1) there will be 70,000 more physicians than required in 1990; (2) there will be a surplus of most specialties; (3) the primary care specialties of family practice, general internal medicine, general pediatrics, and osteopathic general practice will be in balance; and (4) shortages will be experienced in preventive medicine, psychiatry, and emergency medicine.[4] A recent revision, based on a refinement for six specialties, resulted in a GMENAC surplus estimate of 63,000 by 1990 and 137,000 by 2000.[5] For reference purposes, all U.S. medical school students and residents last year numbered about 137,000.

My purpose here is not to explain differences in the methodology approaches used by the Bureau of Health Professions and by GMENAC. Clearly, the concern with a national shortage of physicians that existed in the early 1960s is not a concern that exists in the early to mid 1980s. Supply has increased sharply since the early 1960s and will continue to increase sharply. My purpose, consequently, is to discuss potential implications of these developments on a national basis.

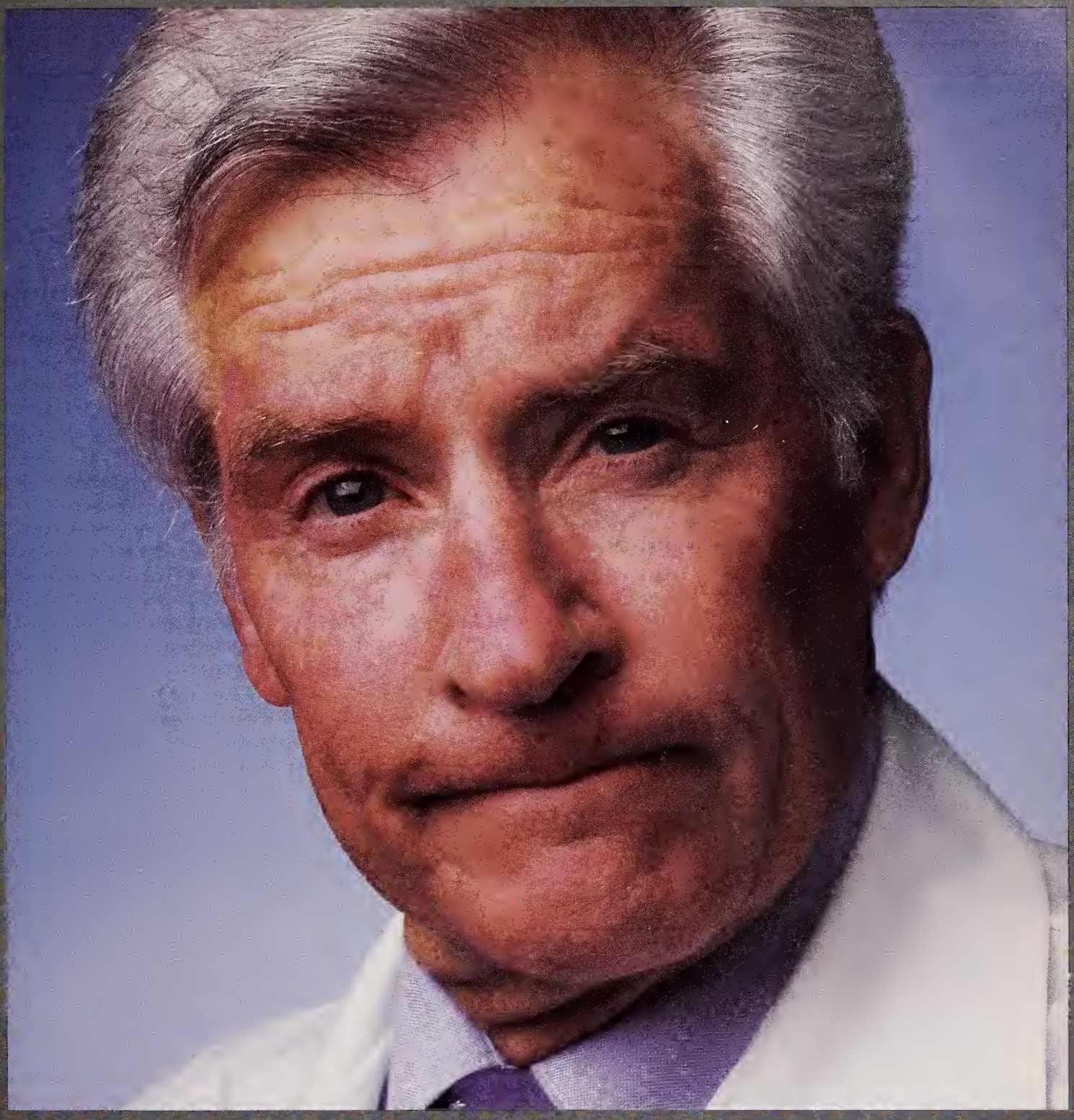
Geographic Distribution

The term geographic diffusion was introduced into the discussion of health manpower policy with the report of a study by Schwartz et al in 1980.[6] The extent of diffusion in the geographic distribution of physicians has since become a matter of intense policy interest.

Two studies undertaken by Rand showed that physicians were increasingly locating in less densely-populated areas. One study specifically focused on board-certified physicians in a select group of specialties and diffusion between 1960 and 1977.[7] Data indicated that in 1977 diplomates appeared for the first time in very small metropolitan areas. A more recent study conducted by Rand lent further support to the possibility that as the supply of family practitioners increased, underservice in rural areas may decrease, since physicians in specialties that grew the most were more likely to move into underserved towns.[8]

According to Brown, Hixson, and Musgrave,[9] forecasts of the movement of primary care physicians over the period 1982 to 1994 predict substantial physician diffusion in the years ahead. Their model predicts that increasing numbers of new primary care physicians will gradually but systematically locate in counties with less dense concentrations of practitioners as time goes on. For the number of counties with a ratio above 3500-to-1, the current criterion for eligibility for designation as a Health Manpower Shortage Area, their projections show a drop by almost 60 percent.

Most observers suggest that a likely consequence of the increasing supply of practicing physicians will be that more physicians will locate in counties having lower physician-to-population ratios. Such



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diffusion is projected to continue. It should be noted, however, that even with the dramatic increases in the aggregate numbers of physicians to date, there continue to be persistent problems of geographic distribution. It remains unclear whether the gross numbers of personnel will ultimately cause this situation to self-correct or not.

Other Measures of Access

The expanding supply of physicians may affect measures of access other than just the geographic distribution of available services. Whereas in 1964, 66 percent of the U.S. population had contact with a physician within the past year, by 1975 the percentage had increased and leveled off at 75 percent. The average length of a physician visit may be increasing. In 1980, there was a slight decrease in the percentage of visits which lasted less than 10 minutes. Furthermore, increases in the supply of physicians may be related to increases in quality amenities associated with health care, such as decreases in patient waiting time.

Graduate Medical Education and Specialty Trends

Substantial changes have occurred in graduate medical education over the last decades. The number of residents across all years of training was 75 percent greater in 1982 than in 1970, with the greatest increases seen in the primary care specialties. In the 1982-83 academic year, over 50 percent of all residents were in training programs in internal medicine, pediatrics, and obstetrics/gynecology, compared to 33 percent in 1970.[10]

Data from the National Resident Matching Program (NRMP) show an emerging imbalance between entry level GME training positions and applicants. Some have argued that the sharp increase in the U.S. medical school graduates, combined with a leveling off in the number of graduate training positions in U.S. hospitals, have been major factors in the developing mismatch. Quite recently, however, this concern of an impending residency shortage has come under debate. Two reports of the AMA Council on Medical Education consider positions both in and out of the match and conclude that such a shortage is not near. The NRMP included almost 18,000 positions to begin this past July; this contrasted with a figure nearly 3,500 more as reported in the AMA special residency survey.

The issue of the proper mix of specialties — both within professions and between professional groups — continues to be a matter of concern. While the primary care movement has been significant for physicians, there appears to be a leveling off in the growth. Utilizing GMENAC's definition of surplus as supply over 20 percent of requirements, specialties projected to be in surplus by 1990 range from urology, diagnostic radiology, and orthopedic surgery (20-35 percent) to cardiology, endocrinology, neurosurgery, and pulmonary (90-95 percent). Other specialties projected by GMENAC to exceed requirements by 50 percent include general surgery and the medical subspecialties of allergy/immunology, nephrology, and rheumatology.

Many observers believe that increasing proportions of the new physicians will not enter the primary care specialties unless the residency mix changes significantly and/or the financing structure leans heavily toward the reimbursement of primary over specialized care.

In the coming years, given recent trends, it would seem likely that an increasing number of young physicians may be more receptive to alternative modes of practice, to accepting a salaried position, or to joining the staff of a prepaid plan. The receptivity of a larger number of physicians to such positions, along with new and expanded forms of delivery organization, may profoundly impact specialty trends.

Health Care Expenditures and Physician Income

Several very limited empirical studies suggest that increasing the availability of physician services will increase total spending for medical services, but at a rate far less than the proportionate increase in supply, thus leading to a reduction in the real income of physicians.

In a recent study, Davis analyzed expenditures and utilization of medical services in different sections of the United States in relationship to the per capita availability of physicians.[11] Using 1978 data, she found that in those areas of the country with high physician-to-population rates, expenditures are higher for all aspects of medical care, but the net earnings of the physicians practicing in these highly doctored areas are lower than their peers in other sections of the country.

The increased economic competition among providers may result in moderation of costs, enhanced quality, improved access, and availability of health care.

Two Canadian economists analyzed the relationship between medical expenditures in the 10 Canadian provinces over the period 1957-1971 and the physician/population ratio in those areas.[12] The results of this analysis suggest that expenditures on physician services will rise as per capita supplies of physicians increase, but that this rise is not infinite and can turn around if supplies increase too far. In another interesting analysis, Weil suggests that in-

creasing numbers of physicians in a community after a while can actually lead to reductions in the use of hospital inpatient and outpatient facilities.[13]

In brief, the implications of an increased supply of physicians are complex and still not well understood. One extreme view might suggest the following outcomes: (1) an "ethical breakdown" as competition for patients and pieces of the "economic health care pie" accelerate among providers; (2) substantial "over doctoring" of the population; concomitant increase in iatrogenic morbidity; unwarranted and disproportionate national concern with "illness"; (3) major increases in utilization, with a massive overburden on our nation's financing capability; and (4) severe market competition leading to relative income reductions for physicians, diminished incentives for new entrants into the profession, and a substantial drop in the "quality" of practitioners.

The increased supply of physicians may enhance competition for entry into the profession, with an upgrade in the quality of practitioners.

A sharply contrasting view might suggest the following outcomes: (1) increased economic competition among providers resulting in moderation of costs, enhanced quality, improved access, and availability of health care; (2) alleviation of geographic and specialty distribution imbalances; (3) enhanced competition for entry into the profession, with an upgrade in the quality of practitioners; (4) promotion of new and worthwhile specialty areas and related practice disciplines; (5) broadening the base of health services offered to consumers; and (6) a burgeoning of research and innovation.

Whether the increased supply is "good" or "bad" may depend, in part, upon who is asking the question. From whose perspective should the effects of an increasing physician supply be determined?

For example, should it be the perspective of the practitioner who may find a lessened demand and possibly reduced income a serious financial problem meeting the income levels he had anticipated and planned for in his younger days? Or, the practitioner who seizes the opportunity to ease off from the long years of hard work and busy schedules and decides to retire? Or, an innovative practitioner who may find a way to increase the services she provides, lower her fees, and increase productivity without suffering income loss? Should it be the perspective of residents of an isolated area pleased to see a physician establishing a practice there? What about the perspectives of patients, medical school students, recent graduates, residents, the medical profession and specialty societies, third party payers, hospitals, medical schools, program directors, government, tax payers?

Problems clearly continue to exist. As noted earlier, there continue to be persistent problems of geographic distribution. The issues of the proper mix of specialties and cost of health care are yet to be resolved. How to operationalize and integrate the concept of health promotion and disease prevention into our health system also continues as a major issue.

Assuring access of minorities and the disadvantaged to the health professions clearly represents a continuing area of concern. Substantial gains in minority enrollment registered in the late 1960s and early 1970s have not been repeated in recent years, despite concerns over a shortage of minority physicians. This past fall, the proportion of underrepresented minorities in total U.S. medical school enrollment numbered 8.3 percent for the third straight academic year. The first year enrollment proportion, 9.7 percent, although up slightly from the preceding year, was still somewhat below the peak reached in 1974-75.

An eloquent statement of trends among black medical students was recently reported in a Robert Wood Johnson Foundation-supported study with a grant to the Morehouse School of Medicine (carried out with the cooperation of the Association of Minority Health Professions Schools).[14] This past fall, blacks accounted for 6.8 percent of all first-year medical students, relatively unchanged from 2 years ago and down from the peak levels of mid-1970s.

In addition to such issues, uncertainties also clearly continue to exist. How will staffing privileges be affected by the increased numbers of physicians? What will be the impact upon all the other health professions whose supply also greatly increased over the last 10 to 20 years? How will increased numbers of physicians mix with the growth of DRGs? What will be the course of GME positions?

In today's environment of tight resources and changing relationships among the various levels of government, and between government and the private sector, the job of dealing with these problems and uncertainties will continue to be difficult.

Action by individual states and states collectively is clearly on the upswing. Medical spokespersons in Alabama, California, Illinois, Michigan, New York, Ohio, Pennsylvania, and South Carolina, furthermore, have commented that their states show signs of oversupply. Reevaluations are being directed to medical education policies. Reassessment is also being directed to policies regarding physician recruitment and retention, graduate medical education, reimbursement change, and government-private sector relationships. The environment is clearly fluid. The debate is clearly alive.

(Continued on page 554)

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For further information about Charter By-The-Sea or admission procedures, contact:

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Hospital Administrator: James R. Thomas

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Hiking — *Continued from p. 546*

many stops along the way. The Berensons hiked along a section of the trail called the John Muir Trail, constructed during 1928-1930 by the National Park Service. They covered 270 miles and reached the top of Mt. Whitney which towers 14,496 feet above sea level, and is only 100 miles from Death Valley, the lowest point in the continental United States. Named for Josiah Dwight Whitney (1819-1896), an American geologist and professor at Harvard University, Mt. Whitney, with its igneous and volcanic rock formations, its magnificent forests covered with evergreens such as tamarack, pine, cedar, and Douglas fir, and its numerous cascades and rapids, provided the Berensons with many opportunities for picture-taking.

In June, 1984, Dr. Berenson joined a friend from Atlanta and flew to Pennsylvania to pick up where he last left off and cover more miles along the Appalachian Trail. He would like some day to complete the entire 2000 miles of the trail, but at the rate he has to go, he estimates that this will require another 10 years.

editorial
editorial
editorial

The Practitioner and AIDS

STARTING WITH ITS RECOGNITION in May, 1981, to the first description of the putative agent in May, 1983, the natural history of our knowledge of the acquired immunodeficiency syndrome (AIDS) has been a truly remarkable story. The three articles on AIDS in this issue of the *Journal* clearly capture the essence of this extraordinary scientific discovery. The discussions include the diagnosis, clinical management, and description of 10 cases of AIDS from Georgia; an outline of some of the psycho-social problems of patients with AIDS; and a nationwide summary of the pertinent clinical and epidemiologic aspects of AIDS.

However rapid the pace and spectacular the findings have been, the narrative of this unique disease could not have been told without private practitioner, public health official, and basic scientist each making an essential contribution to the saga of AIDS. Yet, as with other new diseases, such as Legionnaires' disease and toxic shock syndrome a few years ago, the essential component in the search for answers to public health concerns is the recognition and reporting of cases by the private practitioner.

On June 5, 1981, the Centers for Disease Control (CDC) published in its *Morbidity and Mortality Weekly Report (MMWR)* a report from several practitioners in Los Angeles describing five cases of *Pneumocystis carinii* (PCP) among male homosexuals. By July 3, 10 more cases of PCP among homosexual males, plus 26 cases of Kaposi's sarcoma in the same population subgroup, were recognized by physicians in California and New York. By late August, 70 more cases of Kaposi's sarcoma and/or PCP were reported to CDC by physicians from Los Angeles, San Francisco, and New York City.

Other reporting milestones that followed soon thereafter included the recognition of various opportunistic infections associated with AIDS, other clinical presentations such as generalized lymphadenopathy and undifferentiated non-Hodgkins lymphoma, and epidemiologic evidence of person-to-person spread among male homosexuals. However, probably the most single important report from a public health point of view came from physicians in New York, Colorado, Florida, and Ohio, who in July, 1982, diagnosed PCP among persons with hemophilia A — the first indication that this constellation of syndromes could be transmitted by blood products.

By September, 1982, a new name was added to the medical lexicons, "acquired immunodeficiency syndrome," by then a nationally and internationally known disease. Numbers of case reports continued to increase from other major population centers including Atlanta, and by early 1983, a firm association had been made between AIDS and both blood transfusions and intimate sexual contact. As numbers of cases rose, epidemiologists and basic scientists had more opportunities to collect data on high-risk populations and clinical specimens upon which to attempt microbiologic studies. At this writing, the causative agent of AIDS is believed to be a retrovirus called lymphadenopathy-associated virus (LAV) by some and human T-lymphotropic virus (HTLV-III) by others (Figure 1).

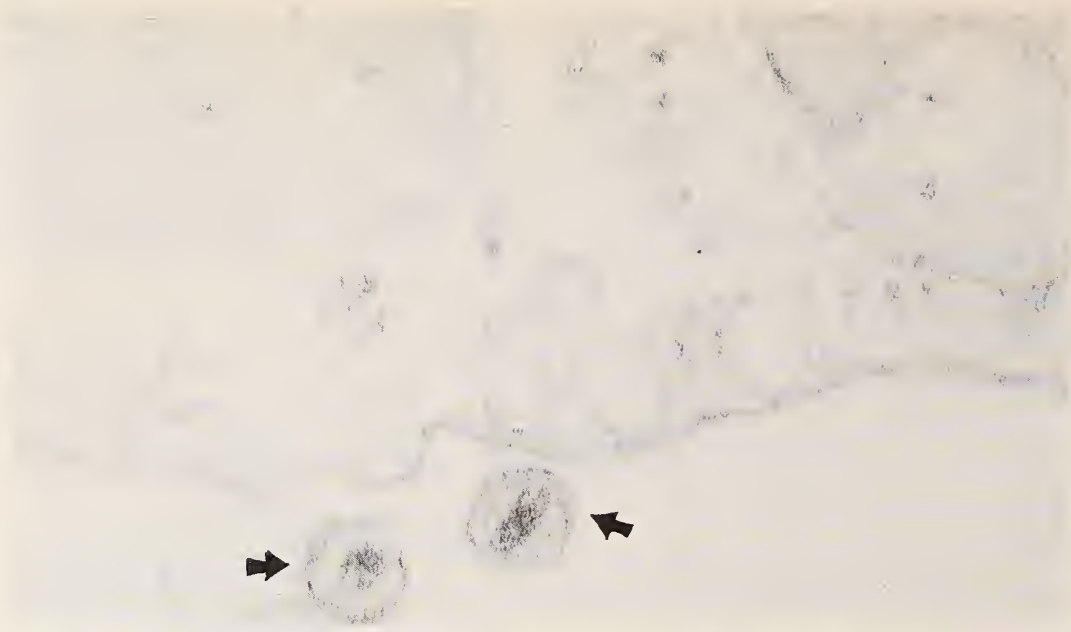


Figure 1 — Lymphoadenopathy-associated virus (LAV) preparation; 3-day infected culture of white blood cells. The picture contains extracellular, mature retrovirus particles. The particles are 90-100 nanometers. Overall magnification is 138,000x. Source: Division of Viral Diseases, Centers for Disease Control.

Were it not for this extraordinarily rapid recognition and reporting by physicians, some of the most basic clinical, epidemiologic, and laboratory evidence would doubtless still be lacking. Nor would there presently be a reasonably firm basis for screening blood donors and a protocol for handling infectious material in hospitals.

Yet despite these scientific advances in unraveling the AIDS story, the continued recognition and reporting of AIDS will be absolutely essential to our further understanding of this complex disease. The medical community must maintain close, intensive surveillance of AIDS to answer such critical questions as: What really is the clinical spectrum of disease? What are the dynamics of patient infectiousness? What is the true incubation period? Will the disease spread to other parts of the world? Are there other high-risk groups as yet unidentified? How successful are the present methods for screening blood donors? How effective are the recommendations for minimizing exposures among health care workers? Although several serologic tests are now available to screen for exposure to the presumed virus, their sensitivity and specificity are yet to be fully established. With a disease whose incubation period may be 1-4 years, answers to such questions may be a long time in coming. The hope of creating an effective vaccine for high-risk populations is a real one; however, much more work needs to be done before initial efficacy studies can be started.

The answers to most if not all these questions will depend entirely upon the constant recognition and reporting of AIDS patients and patients with similar syndromes by the practicing physician. Careful clinical and epidemiologic analyses with special attention to the fine points of exposure and contact will be critical in formulating any reasonable answers. This year AIDS became a nationally reportable disease — like many other infectious diseases. Most states require reporting or are considering requiring physicians to report this disease on a regular weekly basis.

The approximately 5,000 cases reported nationally have so far provided a tremendous wealth of information in a very short period of time. The practicing physician must continue to play the key role in this unfolding, historic scientific process.

Michael B. Gregg, M.D.
Deputy Director for Communications
Epidemiology Program Office
Centers for Disease Control
Atlanta

Percutaneous Transluminal Coronary Angioplasty

MARK LIBOW, M.D., and
ANDREAS R. GRUENTZIG, M.D., *Atlanta**

ALTHOUGH THE CONCEPT of treating atherosclerotic obstructions in peripheral arteries with catheters dates back to the work of Dotter and Judkins in 1964,[1] it was not until 1977 that balloon dilatation of coronary arteries was introduced.[1] Coronary artery disease afflicts 5% of the American population and causes over 600,000 deaths per year. Though over 100,000 aortocoronary saphenous vein bypass operations are performed each year, percutaneous transluminal coronary angioplasty (PTCA) is an alternative mode of therapy in selected patients. Our purpose is to describe the technique, patient selection, and adjunctive therapy of this new and exciting technique.

Technique

In our institution, PTCA is performed using the percutaneous transfemoral approach. Aspirin 650mg and Nifedipine 10mg are given on the night prior to PTCA. At the start of the procedure, sublingual Nifedipine and nitroglycerin are administered to prevent coronary spasm. Low molecular weight Dextran and 10,000 units of Heparin are given to minimize platelet thrombus formation in the area of angioplasty. Coronary angiography is performed first to ensure that there has been no substantive change in the patency of the affected coronary artery since the last catheterization. Surgical assistance is available, should it be needed, in case of sudden closure or other complications. Percutaneous insertion of a temporary transvenous pacemaker is then done as a prophylactic measure.

A Judkins-type guiding catheter is introduced through a sheath and is positioned at the orifice of the affected coronary artery. Occasionally, multipurpose or Rowe-Castillo-Amplatz-shaped guiding catheters are used, especially for bypass graft lesions, or difficult right coronary or circumflex lesions. Sometimes it is necessary to shorten or modify the catheter tip by heating with hot air. Usually French 8 catheters are used for patients with small coronary ostia and French 9 catheters for large coronary ostia. Since the guiding catheter is not tapered at the end, it allows passage of a double-lumen balloon catheter after a guidewire is first advanced through the stenosis. Controlled rotation of the distal tip of the guidewire facilitates its passage through tortuous vessels and severely stenotic lesions. High-resolution television systems and biplane fluoroscopy aid in monitoring passage of the guidewire and balloon through the affected coronary artery.

* From the Department of Medicine (Cardiology), Emory University School of Medicine, Atlanta. Send reprint requests to Dr. Gruentzig, International Cardiovascular Medicine, Emory University Hospital, 1364 Clifton Rd., NE, Atlanta, GA 30322.

Articles for this Page are sponsored and approved by the American Heart Association, Georgia Affiliate. Those wishing to contribute papers to this Page are invited to send them to Dr. Laurence O. Watkins, Heart Page Editor, Section of Cardiology, Dept. of Medicine, MCG, Augusta, GA 30909.

Initial selection of the balloon is made on the basis of size of the coronary artery and severity of the stenosis. The outer dimension of the balloon most commonly employed is 3.0mm. A 3.7mm balloon is used for larger arteries. For severe obstructions, a 2.5mm balloon or a modified low-profile balloon with a tapered tip is used.

The balloon is filled with a mixture of contrast material and saline which allows visualization while inflation is being accomplished. Prior to inflation, the initial gradient is assessed by measuring pressures from the tip of the guiding catheter in the coronary ostium or aorta and from the tip of the balloon catheter distal to stenosis. Multiple inflations are usually performed until the dumbbell-shaped contour of the balloon imposed by the lesion disappears and reduction of the pressure gradient is achieved. Distal injections of contrast dye are made following each inflation to determine whether flow has improved. Inflation time varies from 10-to-30 seconds and inflation pressure ranges from 2-to-12 atmospheres.

The indications for PTCA have been disabling angina pectoris, ischemia, and a high-grade stenosis of one coronary artery amenable to dilatation.

Withdrawal of the catheter with continuous pressure recording is done at the conclusion of the procedure to assess the hemodynamic result. The dilatation catheter is withdrawn and coronary arteriograms are performed in different projections. Using a computerized electronic caliper, the stenosis is measured in three views. Following the procedure, Protamine is not administered to reverse the effect of Heparin. The catheter sheaths are usually removed 2 hours later. When a large intimal tear is apparent in the region of the dilatation, an infusion of Heparin and nitroglycerin is given overnight.

All patients undergo continuous ECG monitoring via telemetry, and a repeat 12-lead ECG is obtained. Cardiac enzyme levels are measured immediately after angioplasty and 8 to 16 hours later. Administration of aspirin, nitrates, and calcium antagonists is always done in this initial phase after completion of the procedure.

The patient is discharged 2 days later after a treadmill exercise test has been performed according to the Bruce protocol. In some cases, first-pass radionuclide angiography or thallium scintigraphy is used in conjunction. Aspirin is prescribed for at least 6 months as adjunctive therapy except when contraindicated. Follow-up angiography is recommended at 6 months and is performed earlier if symptoms recur. A follow-up treadmill exercise test is also advised during the initial 6 months.

Patient Selection

The indications for PTCA have been angina pectoris causing sufficient disability to warrant bypass surgery, objective evidence of ischemia, and a high-grade stenosis of one coronary artery amenable to dilatation. In rare circumstances (less than 2% of our cases), PTCA has been undertaken in asymptomatic individuals with abnormal exercise tests. The angiographic criteria have been expanded to include severe disease in one vessel with insignificant disease in another vessel, and double vessel disease in which both stenoses are ideally suited for PTCA.

Consideration should be given to the severity and eccentricity of the lesion, presence of calcification and tortuosity of the vessel proximal to the stenosis, although there are no absolute morphologic contraindications. Our experience indicates that lesions which are severe or eccentric are associated with lower primary success rates and higher complication rates.[3] Heavily calcified lesions indicate chronic disease which may be too rigid to undergo balloon dilatation. The location and number of side branches are important, especially when obstructions are present at bifurcations of large vessels: balloon dilatation may lead to occlusion of one vessel while the other is being dilated. For the most part, however, the

incidence of side branch occlusion is low (5% of vessels in jeopardy) and usually involves those vessels which are intimately involved in the lesion to be dilated.[4] Significant consequences of this occlusion, as judged by follow-up ECG and creatine kinase levels, are usually not seen, but this holds true only if small branches are encountered. Involvement of proximal diagonal vessels may require alteration of the technique or may preclude performance of PTCA.

Left main coronary artery obstruction is a relative contraindication, although a few such cases have been done. The length of the coronary stenosis is important, as most dilating catheters have balloon segments 25mm in length. In contrast, multiple lesions in the same vessel do not pose much difficulty. Patients with prior coronary bypass surgery are candidates for dilatation, especially when the vein graft is stenotic at the distal, anastomotic site. Our experience indicates that re-stenosis is infrequent (less than 20%) at this site and common (50%) in the proximal anastomosis and body of the vein.[5] The National Heart, Lung, and Blood Institute (NHLBI) PTCA Registry reports somewhat higher mortality rates in this group of patients when angioplasty is unsuccessful and emergency bypass surgery is required.[6]

Results

The primary success rate in our 2,000 attempts in Zurich and Atlanta between 1977 and 1983 was 88%. Primary success is defined as ≥20% reduction in average luminal diameter narrowing of the stenosis and reduction of the pressure gradient. Patients who suffer a myocardial infarction or require bypass surgery during hospitalization are not counted as primary successes. Success is inversely related to the severity and eccentricity of the stenosis, but is unaffected by the length of the lesion. Failures are divided into emergency and non-emergency cases. Non-emergency failures are those in which the stenosis could not be crossed or a major complication occurred. With the advent of the steerable wire systems in 1982, the number of cases in the former group above has been reduced. As far as the latter group is concerned, myocardial infarction associated with ECG changes occurred in 1.5%. Enzyme elevations without ECG changes occurred in an additional 139 (6.9%). There have been only two inhospital deaths.

Emergency failures were those cases in which coronary artery bypass surgery was required. This was usually due to coronary artery dissection with occlusion or unresolved spasm. The incidence in our 2,000 attempts is 3.5%.

Results from the NHLBI Multicenter Registry have shown what can be expected in a learning period.[6] They reveal a primary success rate of 61% in 3,079 patients. Of these, 72.5% had single vessel disease, 25% had multiple vessel disease, and 2.5% had left main disease. The primary success rate in early reports from NHLBI was higher in left anterior descending stenoses and lower in circumflex obstructions. In 25% of attempted angioplasties, the balloon could not be passed and in 8% the lesion could not be dilated. Complications occurred in 21% of cases, the most frequent being prolonged angina, myocardial infarction, and coronary occlusion. Less frequent complications included ventricular fibrillation, hypotension, bradycardia, coronary embolism, and arterial thrombosis requiring surgery. The mortality rate was 0.9%. Emergency bypass surgery was required in 6.6%, usually for a coronary dissection or occlusion. Nonfatal myocardial infarctions occurred in 5.5% of patients. Nonfatal complications were more frequent in patients with unstable angina or in patients with stenosis greater than 90% of the luminal diameter. There was a decreasing frequency of complications as the number of patients increased, a further indication of the existence of a learning curve. This suggests that the complication frequency should continue to decline in the future.

Follow-up Data

Recurrent stenosis, defined as a 50% loss in the initial gain in the diameter narrowing, usually occurs within the first 2-5 months. Restenoses are detected in 33% of patients undergoing repeat angiography,[7] more often in men and in

diabetics. Left anterior descending lesions were more likely to restenose than right coronary or circumflex lesions. Lesions with lower residual gradients are less likely to restenose than lesions with high residual gradients, but the degree of reduction in diameter narrowing does not affect the likelihood of restenosis. Repeat PTCA seems to be more successful and safer than the initial procedure.[7] This may be due to the fact that the initial PTCA was successful. Previously dilated arteries differ in their histologic characteristics from virgin arteries, and this may contribute to the higher success rate.[8]

Conclusion

PTCA will not replace bypass surgery. The majority of patients with symptomatic angina have multiple stenotic lesions or occlusions; they are candidates for bypass surgery. It is estimated that 15% of patients with coronary artery disease requiring bypass surgery could be treated with angioplasty. Technical improvements such as the development of the steerable guidewire system, new higher pressure balloons, and high resolution fluroscopy will broaden the spectrum of candidates suitable for PTCA. As angiographers become more experienced at PTCA, the success rate should increase and the incidence of complications should decrease. Experienced teams now perform double vessel PTCA if both lesions are suitable.

The potential of PTCA as an effective therapy for atherosclerotic disease will be realized in the 1980s and beyond.

Since coronary artery disease is a chronic, progressive disorder, it is conceivable that PCTA might be used repeatedly in different vessels in the same patient over a period of decades. The potential of PCTA as an effective therapy for atherosclerotic disease will be realized in the 1980s and beyond.

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Recent Developments in Georgia Relating to "Wrongful Pregnancy" Actions

ROBERT N. BERG, *Atlanta**

UNTIL RECENTLY, no Georgia court had been faced with the question of whether or not the law in Georgia authorized the institution of an action for "wrongful pregnancy" — an action brought by the parents of a child whose conception or birth allegedly was due to a physician's negligence in performing a sterilization or abortion procedure. Earlier this year, however, the Georgia Supreme Court issued two opinions in "wrongful pregnancy" actions. In the first case, the Supreme Court held that Georgia law in fact recognizes the existence of a cause of action for "wrongful pregnancy"; at the same time, the Court imposed significant limitations on the damages recoverable in that type of lawsuit. In the second case, the Court did not reach the merits of the "wrongful pregnancy" claim. Instead, the Court held that the application of the Georgia statute of limitations for medical malpractice actions to a "wrongful pregnancy" action, where the pregnancy occurred more than 2 years after the allegedly negligent performance of the sterilization procedure, was unconstitutional.

These two recent Supreme Court cases are the subject of this month's Legal Page.

"Wrongful Pregnancy" Actions May Be Brought In Georgia

In *Fulton-DeKalb Hospital Authority v. Graves,*[1] the Supreme Court was faced for the first time with the question of whether Georgia law recognizes a cause of action for wrongful pregnancy or wrongful conception and, if so, whether the damages recoverable include the cost of rearing and educating the child. The facts surrounding the case involved a plaintiff mother who, following the birth of a healthy child in 1979, allowed a sterilization procedure to be performed upon her by a staff physician of the defendant hospital. Subsequently, the mother gave birth to another child, and sued the defendant hospital for negligence and for fraudulent misrepresentation with respect to the sterilization. The trial court denied summary judgment to the hospital on its contentions that (a) no cause of action existed in Georgia for wrongful pregnancy, and (b) if such a cause of action did exist, that the measure of damages was limited to the pecuniary expenses incurred as a direct result of the birth (i.e., no damages could be obtained for expenses relating to raising and educating the child following birth). The hospital then appealed to the Supreme Court.

Initially, the Supreme Court found "no reason why an action for wrongful pregnancy or wrongful conception should not be recognized in Georgia. Such an

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* Prepared at the request of the Medical Association of Georgia. Mr. Berg is an associate in the firm of Powell, Goldstein, Frazer & Murphy, General Counsel to the Association, 1100 C & S National Bank Building, Atlanta, GA 30335.

action is no more than a species of malpractice which allows recovery from a tort-feasor in the presence of an injury caused by intentional or negligent conduct.''[2] In doing so, the Court relied heavily on certain United States Supreme Court decisions recognizing that a woman has a constitutional right to plan the size of her family;[3] it also rejected the argument that recognition of a cause of action for ''wrongful pregnancy'' would open the door to fraudulent claims, finding that ''these same arguments have been made in connection with countless other tort claims, and the problems presented have been dealt with in the course of traditional tort litigation.''[4] However, the court made it clear that its decision was limited only to cases involving ''wrongful pregnancy,'' and did not involve sanctioning ''an action brought by a child against the parents or physicians on the theory that because of [the child's] illegitimacy or birth defect he would have been better off not born.''[5]

Once recognizing the existence of a cause of action for ''wrongful pregnancy'' in Georgia, the Court next considered the question of the appropriate measure of damages. The Court did so by dividing the damages issue into two parts: (a) damages directly associated with the cost of the medical procedure involved and the subsequent birth; and (b) costs incurred subsequent to the birth of the child, such as those involved in rearing and educating the child. As to the first category of damages, the Court summarily found them to be consistent with the damages recoverable in any malpractice case, and therefore subject to recovery. Specifically, the Court stated that ''(t)he vast majority of courts allow recovery of expenses for the unsuccessful medical procedure which led to the conception or pregnancy, for pain and suffering, medical complications, costs of delivery, lost wages, and loss of consortium.''[6]

The second type of damages proved to be a much more difficult problem for the Court. On the one hand, ''(i)n evaluating a claim for the cost of rearing a child, [the Court] must consider the value which our society places upon human life in general and on the lives of children in particular. We instinctively recoil from the notion that parents may suffer a compensable injury on the birth of a child.''[7] On the other hand, the Court noted that various other states faced with this problem had adopted a method of compensating the parents for the costs of rearing and educating their children by offsetting against those costs an amount designed to quantify the ''benefits'' obtained by the parents in having the child.

Ultimately, the Court rejected the use of this offset procedure, concluding that it was an inappropriate method of dealing with an ''area of delicate human relations,'' and that, as a result, the cost of raising a child is not compensable damages and cannot be recovered under Georgia law. In particular, the Court noted that ''(t)he soundness of a rule denying recovery for the cost of raising a child lies in that, given the values cherished by our society, a parent cannot be said to have suffered an injury in the birth of a child.''[8]

Medical Malpractice Statute of Limitations Held Unconstitutional . . . Again

The second ''wrongful pregnancy'' case, *Shessel v. Stroup,*[9] dealt not with the viability of a cause of action for ''wrongful pregnancy'' but with the question of how to apply the 2-year medical malpractice statute of limitations to that type of action. In *Shessel,* the parents brought an action against a physician, alleging that he negligently performed a sterilization procedure on the mother, with the result that she later became pregnant and give birth to a child. Since the sterilization procedure was performed on April 3, 1978, and since the lawsuit was filed on November 16, 1982,[10] the physician defended on the grounds that the 2-year medical malpractice statute of limitations had expired and therefore barred the claim.[11] The trial court disagreed, finding that application of the 2-year medical malpractice statute of limitations so as to bar the plaintiffs' claim was unconstitutional. On appeal, the Georgia Supreme Court agreed.

The Supreme Court first acknowledged that the medical malpractice statute of limitations, which defines an action for medical malpractice and establishes a

limitation upon the time within which a medical malpractice suit must be brought, "removes the action from the general tort statute of limitations." Thus, while a typical negligence suit must be brought within 2 years from the date upon which the injury resulting from the negligence is sustained, a suit for medical malpractice must be brought within 2 years from the date on which the negligent act itself occurred.

The Court also acknowledged that, subsequent to the enactment of the medical malpractice statute of limitations, it had held on several occasions that there was a rational basis for the separate classification of medical malpractice actions from other tort actions, and that, as a result, the medical malpractice statute of limitations was not violative of the constitutional guaranty of equal protection.[12] These holdings, however, were prior to a more recent Supreme Court holding, in *Clark v. Singer,*[13] which had involved a particular type of malpractice action — a "wrongful death" action. In *Clark,* the Court had found that "at least three classifications among wrongful death actions existed: (1) the general tort limitation of 2 years provided in [the general tort statute of limitations] which applies to most wrongful death actions and runs from date of death, not date of injury nor date of negligence; (2) a medical malpractice claim where death occurs within 2 years of the negligent act; and (3) a medical malpractice claim where death occurs more than 2 years after the negligent act."[14]

To the Court, this "three-way classification" went beyond the mere distinction between all medical malpractice actions and all general tort actions. Accordingly, in *Clark,* the Court had rejected the argument that "the three-way classification which depended upon the arbitrary date of death in medical malpractice cases, and thereby allowed an action to be brought in all general tort cases, and in some medical malpractice cases, but not in other medical malpractice cases, bore a substantial relation to the object of the legislation, so that all persons similarly circumstanced shall be treated alike."[15] Thus, in *Clark,* the Court held the medical malpractice statute of limitations to be unconstitutional as applied to wrongful death actions.

In *Shessel,* the Court reached a similar conclusion in applying the medical malpractice statute of limitations to "wrongful pregnancy" cases. In the Court's view, the causes of action were similar: "Just as a wrongful death action may not be brought until death occurs, a personal injury claim may not be brought until there is an injury. Therefore, we have the same arbitrary three-way classification held unconstitutional" in *Clark.*[16] Specifically, the Court identified the same untenable three-way classification in connection with "wrongful pregnancy" cases as it did with regard to wrongful death cases: "All general tort claims survive until there is injury, some [wrongful pregnancy] claims survive until there is injury and some [wrongful pregnancy] claims do not."[17]

As a result, the Court found "no substantial relation in this three-way classification to the object of a limitations statute. All who are similarly situated are not treated alike. We hold that [the medical malpractice statute of limitations] is a denial of equal protection and therefore unconstitutional. . . ."[18]

Conclusion

The Supreme Court's decision in *Graves* may be viewed as "good news/bad news" to physicians. On the one hand, it is now clear that a physician who negligently performs a sterilization or abortion procedure may be held liable to the parents for damages arising out of the physician's negligence. On the other hand, those damages will be limited to the expenses directly arising out of the procedure and the subsequent birth of the child, and will not include the costs and expenses of raising and educating the child.

Unfortunately, it does not appear that the Court's decision in *Shessel* can be similarly construed. At best, the Court has imposed a significant limitation on the application of the medical malpractice statute of limitations — not only will that statute be inapplicable in wrongful death actions (per the *Clark* decision); it will

also be inapplicable in "wrongful pregnancy" cases where the pregnancy (or some other manifestation of injury arising out of the negligence) occurs more than 2 years after the date of the sterilization or abortion procedure.

It is far more likely, however, that the *Shessel* decision will not be construed so narrowly. Thus, although the actual language used in the opinion could be construed as still allowing application of the 2-year medical malpractice statute of limitations in "wrongful pregnancy" actions where the pregnancy occurs within 2 years from the date of the sterilization or abortion procedure, it is probable that the *Shessel* opinion will be read as effectively doing away with the entire medical malpractice statute of limitations. Simply put, it is now apparent from the Supreme Court's recent decisions (e.g., *Clark* and *Shessel*) that the Court has significant problems with the main premise underlying the medical malpractice statute of limitations — that a malpractice cause of action accrues at the time of the negligent act, rather than at the time of the injury resulting therefrom — and that, in all likelihood, the Court is unwilling to sanction application of the medical malpractice statute of limitations to bar claims that, under the general statute of limitations, would not be barred. (This interpretation finds support, among other things, in the language used by the Court in *Shessel,* relating not only to "wrongful pregnancy" actions but also to "personal injury" actions in general.)[19]

Accordingly, while it may be that there will be at least one further case involving the medical malpractice statute of limitations in order to learn exactly what the Court intended in *Shessel,* it would be prudent for physicians to assume that the general tort statute of limitations will be applicable to all medical malpractice causes of action, be they wrongful death, wrongful pregnancy or personal injury.

Notes

1. ___ Ga. ___ (April 17, 1984).
2. *Id.*
3. See, e.g., *Roe v. Wade,* 410 U.S. 113 (1973); *Griswold v. Connecticut,* 381 U.S. 479 (1965).
4. *Fulton-Dekalb Hospital Authority v. Graves, supra,* note 1.
5. *Id.* The Court did acknowledge in its opinion that such an action "has found almost no support in the law" and thus presumably would not be sanctioned under Georgia law.
6. *Id.;* see, generally, *Annotation,* 83 A.L.R.3d 15 (1978).
7. *Id.*
8. *Id.* It should be noted that one Justice dissented from the Court's holding on this point, on the basis of his belief that the costs of raising a child are not too speculative and are a reasonably foreseeable consequence of a negligently performed sterilization or abortion procedure.
9. ___ Ga. ___ (May 31, 1984).
10. The mother first learned of her pregnancy in May, 1981 and gave birth to a healthy child "several months later in 1981." *Id.*
11. O.C.G.A. §9-3-71.
12. See, e.g., *Hamby v. Neurological Associates,* 243 Ga. 698 (1979); *Allrid v. Emory University,* 249 Ga. 35 (1982). For a more detailed look at these cases, see Berg, RN: The Continuing Saga of Georgia's Medical Malpractice Statute of Limitations, JMAG (May, 1983), and articles cited at note 7 therein.
13. 250 Ga. 470 (1983).
14. *Shessel v. Stroup, supra,* ___ Ga. at ___ (citations omitted).
15. *Id., quoting Reed v. Reed,* 404 U.S. 71, 76 (1971).
16. *Id.*
17. *Id.*
18. *Id.* Justice Weltner, joined by Justice Marshall, dissented from the majority's decision. In addition, Justice Clarke specially concurred in the majority's decision.
19. In fact, although the Court in some places in the opinion attempted to limit its holding "to the facts of this case," the Court's analysis appears to be focused on "medical malpractice claims," rather than only on "wrongful pregnancy" claims.

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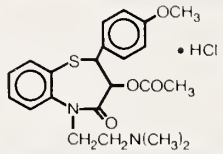
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DESCRIPTION

CARDIZEM® (diltiazem hydrochloride) is a calcium ion influx inhibitor (slow channel blocker or calcium antagonist). Chemically, diltiazem hydrochloride is 1,5-Benzothiazepin-4(5H)one,3-(acetyloxy) -5-[2-(dimethylamino)ethyl]-2,3-dihydro-2-(4-methoxyphenyl)-, monohydrochloride,(+) -cis-. The chemical structure is:



Diltiazem hydrochloride is a white to off-white crystalline powder with a bitter taste. It is soluble in water, methanol, and chloroform. It has a molecular weight of 450.98. Each tablet of CARDIZEM contains either 30 mg or 60 mg diltiazem hydrochloride for oral administration.

CLINICAL PHARMACOLOGY

The therapeutic benefits achieved with CARDIZEM are believed to be related to its ability to inhibit the influx of calcium ions during membrane depolarization of cardiac and vascular smooth muscle.

Mechanisms of Action. Although precise mechanisms of its antianginal actions are still being delineated, CARDIZEM is believed to act in the following ways:

1. Angina Due to Coronary Artery Spasm: CARDIZEM has been shown to be a potent dilator of coronary arteries both epicardial and subendocardial. Spontaneous and ergonovine-induced coronary artery spasm are inhibited by CARDIZEM.
2. Exertional Angina: CARDIZEM has been shown to produce increases in exercise tolerance, probably due to its ability to reduce myocardial oxygen demand. This is accomplished via reductions in heart rate and systemic blood pressure at submaximal and maximal exercise work loads.

In animal models, diltiazem interferes with the slow inward (depolarizing) current in excitable tissue. It causes excitation-contraction uncoupling in various myocardial tissues without changes in the configuration of the action potential. Diltiazem produces relaxation of coronary vascular smooth muscle and dilation of both large and small coronary arteries at drug levels which cause little or no negative inotropic effect. The resultant increases in coronary blood flow (epicardial and subendocardial) occur in ischemic and nonischemic models and are accompanied by dose-dependent decreases in systemic blood pressure and decreases in peripheral resistance.

Hemodynamic and Electrophysiologic Effects. Like other calcium antagonists, diltiazem decreases sinoatrial and atrioventricular conduction in isolated tissues and has a negative inotropic effect in isolated preparations. In the intact animal, prolongation of the AH interval can be seen at higher doses.

In man, diltiazem prevents spontaneous and ergonovine-provoked coronary artery spasm. It causes a decrease in peripheral vascular resistance and a modest fall in blood pressure and, in exercise tolerance studies in patients with ischemic heart disease, reduces the heart rate-blood pressure product for any given work load. Studies to date, primarily in patients with good ventricular function, have not revealed evidence of a negative inotropic effect; cardiac output, ejection fraction, and left ventricular end diastolic pressure have not been affected. There are as yet few data on the interaction of diltiazem and beta-blockers. Resting heart rate is usually unchanged or slightly reduced by diltiazem.

Intravenous diltiazem in doses of 20 mg prolongs AH conduction time and AV node functional and effective refractory periods approximately 20%. In a study involving single oral doses of 300 mg of CARDIZEM in six normal volunteers, the average maximum PR prolongation was 14% with no instances of greater than first-degree AV block. Diltiazem-associated prolongation of the AH interval is not more pronounced in patients with first-degree heart block. In patients with sick sinus syndrome, diltiazem significantly prolongs sinus cycle length (up to 50% in some cases).

Chronic oral administration of CARDIZEM in doses of up to 240 mg/day has resulted in small increases in PR interval, but has not usually produced abnormal prolongation. There were, however, three instances of second-degree AV block and one instance of third-degree AV block in a group of 959 chronically treated patients.

Pharmacokinetics and Metabolism. Diltiazem is absorbed from the tablet formulation to about 80% of a reference capsule and is subject to an extensive first-pass effect, giving an absolute bioavailability (compared to intravenous dosing) of about 40%. CARDIZEM undergoes extensive hepatic metabolism in which 2% to 4% of the unchanged drug appears in the urine. In vitro binding studies show CARDIZEM is 70% to 80% bound to plasma proteins. Competitive ligand binding studies have also shown CARDIZEM binding is not altered by therapeutic concentrations of digoxin, hydrochlorothiazide, phenylbutazone, propranolol, salicylic acid, or warfarin. Single oral doses of 30 to 120 mg of CARDIZEM result in detectable plasma levels within 30 to 60 minutes and peak plasma levels two to three hours after drug administration. The plasma elimination half-life following single or multiple drug administration is approximately 3.5 hours. Desacetyl diltiazem is also present in the plasma at levels of 10% to 20% of the parent drug and is 25% to 50% as potent a coronary vasodilator as diltiazem. Therapeutic blood levels of CARDIZEM appear to be in the range of 50 to 200 ng/ml. There is a departure from dose-linearity when single doses above 60 mg are given; a 120-mg dose gave blood levels three times that of the 60-mg dose. There is no information about the effect of renal or hepatic impairment on excretion or metabolism of diltiazem.

INDICATIONS AND USAGE

1. **Angina Pectoris Due to Coronary Artery Spasm.** CARDIZEM is indicated in the treatment of angina pectoris due to coronary artery spasm. CARDIZEM has been shown effective in the treatment of spontaneous coronary artery spasm presenting as Prinzmetal's variant angina (resting angina with ST-segment elevation occurring during attacks).
2. **Chronic Stable Angina (Classic Effort-Associated Angina).** CARDIZEM is indicated in the management of chronic stable angina. CARDIZEM has been effective in controlled trials in reducing angina frequency and increasing exercise tolerance.

There are no controlled studies of the effectiveness of the concomitant use of diltiazem and beta-blockers or of the safety of this combination in patients with impaired ventricular function or conduction abnormalities.

CONTRAINDICATIONS

CARDIZEM is contraindicated in (1) patients with sick sinus syndrome except in the presence of a functioning ventricular pacemaker, (2) patients with second- or third-degree AV block except in the presence of a functioning ventricular pacemaker, and (3) patients with hypotension (less than 90 mm Hg systolic).

WARNINGS

1. **Cardiac Conduction.** CARDIZEM prolongs AV node refractory periods without significantly prolonging sinus node recovery time, except in patients with sick sinus syndrome. This effect may rarely result in abnormally slow heart rates (particularly in patients with sick sinus syndrome) or second- or third-degree AV block (six of 1243 patients for 0.48%). Concomitant use of diltiazem with beta-blockers or digitalis may result in additive effects on cardiac conduction. A patient with Prinzmetal's angina developed periods of asystole (2 to 5 seconds) after a single dose of 60 mg of diltiazem.
2. **Congestive Heart Failure.** Although diltiazem has a negative inotropic effect in isolated animal tissue preparations, hemodynamic studies in humans with normal ventricular function have not shown a reduction in cardiac index nor consistent negative effects on contractility (dp/dt). Experience with the use of CARDIZEM alone or in combination with beta-blockers in patients with impaired ventricular function is very limited. Caution should be exercised when using the drug in such patients.
3. **Hypotension.** Decreases in blood pressure associated with CARDIZEM therapy may occasionally result in symptomatic hypotension.
4. **Acute Hepatic Injury.** In rare instances, patients receiving CARDIZEM have exhibited reversible acute hepatic injury as evidenced by moderate to extreme elevations of liver enzymes. (See PRECAUTIONS and ADVERSE REACTIONS.)

PRECAUTIONS

General. CARDIZEM (diltiazem hydrochloride) is extensively metabolized by the liver and excreted by the kidneys and in bile. As with any new drug given over prolonged periods, laboratory parameters should be monitored at regular intervals. The drug should be used with caution in patients with impaired renal or hepatic function. In subacute and chronic dog and rat studies designed to produce toxicity, high doses of diltiazem were associated with hepatic damage. In special subacute hepatic studies, oral doses of 125 mg/kg and higher in rats were associated with histological changes in the liver which were reversible when the drug was discontinued. In dogs, doses of 20 mg/kg were also associated with hepatic changes; however, these changes were reversible with continued dosing.

Drug Interaction. Pharmacologic studies indicate that there may be additive effects in prolonging AV conduction when using beta-blockers or digitalis concomitantly with CARDIZEM. (See WARNINGS).

Controlled and uncontrolled domestic studies suggest that concomitant use of CARDIZEM and beta-blockers or digitalis is usually well tolerated. Available data are not sufficient, however, to predict the effects of concomitant treatment, particularly in patients with left ventricular dysfunction or cardiac conduction abnormalities. In healthy volunteers, diltiazem has been shown to increase serum digoxin levels up to 20%.

Carcinogenesis, Mutagenesis, Impairment of Fertility. A 24-month study in rats and a 21-month study in mice showed no evidence of carcinogenicity. There was also no mutagenic response in in vitro bacterial tests. No intrinsic effect on fertility was observed in rats.

Pregnancy. Category C. Reproduction studies have been conducted in mice, rats, and rabbits. Administration of doses ranging from five to ten times greater (on a mg/kg basis) than the daily recommended therapeutic dose has resulted in embryo and fetal lethality. These doses, in some studies, have been reported to cause skeletal abnormalities. In the perinatal/postnatal studies, there was some reduction in early individual pup weights and survival rates. There was an increased incidence of stillbirths at doses of 20 times the human dose or greater.

There are no well-controlled studies in pregnant women; therefore, use CARDIZEM in pregnant women only if the potential benefit justifies the potential risk to the fetus.

Nursing Mothers. It is not known whether this drug is excreted in human milk. Because many drugs are excreted in human milk, exercise caution when CARDIZEM is administered to a nursing woman if the drug's benefits are thought to outweigh its potential risks in this situation.

Pediatric Use. Safety and effectiveness in children have not been established.

ADVERSE REACTIONS

Serious adverse reactions have been rare in studies carried out to date, but it should be recognized that patients with impaired ventricular function and cardiac conduction abnormalities have usually been excluded.

In domestic placebo-controlled trials, the incidence of adverse reactions reported during CARDIZEM therapy was not greater than that reported during placebo therapy.

The following represent occurrences observed in clinical studies which can be at least reasonably associated with the pharmacology of calcium influx inhibition. In many cases, the relationship to CARDIZEM has not been established. The most common occurrences, as well as their frequency of presentation, are: edema (2.4%), headache (2.1%), nausea (1.9%), dizziness (1.5%), rash (1.3%), asthenia (1.2%), AV block (1.1%). In addition, the following events were reported infrequently (less than 1%) with the order of presentation corresponding to the relative frequency of occurrence.

Cardiovascular:	Flushing, arrhythmia, hypotension, bradycardia, palpitations, congestive heart failure, syncope.
Nervous System:	Paresthesia, nervousness, somnolence, tremor, insomnia, hallucinations, and amnesia.
Gastrointestinal:	Constipation, dyspepsia, diarrhea, vomiting, mild elevations of alkaline phosphatase, SGOT, SGPT, and LDH.
Dermatologic:	Pruritus, petechiae, urticaria, photosensitivity.
Other:	Polyuria, nocturia.

The following additional experiences have been noted:

A patient with Prinzmetal's angina experiencing episodes of vasospastic angina developed periods of transient asymptomatic asystole approximately five hours after receiving a single 60-mg dose of CARDIZEM.

The following postmarketing events have been reported infrequently in patients receiving CARDIZEM: erythema multiforme; leukopenia; and extreme elevations of alkaline phosphatase, SGOT, SGPT, LDH, and CPK. However, a definitive cause and effect between these events and CARDIZEM therapy is yet to be established.

OVERDOSAGE OR EXAGGERATED RESPONSE

Overdosage experience with oral diltiazem has been limited. Single oral doses of 300 mg of CARDIZEM have been well tolerated by healthy volunteers. In the event of overdosage or exaggerated response, appropriate supportive measures should be employed in addition to gastric lavage. The following measures may be considered:

Bradycardia	Administer atropine (0.60 to 1.0 mg). If there is no response to vagal blockade, administer isoproterenol cautiously.
High-Degree AV Block	Treat as for bradycardia above. Fixed high-degree AV block should be treated with cardiac pacing.
Cardiac Failure	Administer inotropic agents (isoproterenol, dopamine, or dobutamine) and diuretics.
Hypotension	Vasopressors (eg, dopamine or levarterenol bitartrate).

Actual treatment and dosage should depend on the severity of the clinical situation and the judgment and experience of the treating physician.

The oral LD_{50}'s in mice and rats range from 415 to 740 mg/kg and from 560 to 810 mg/kg, respectively. The intravenous LD_{50}'s in these species were 60 and 38 mg/kg, respectively. The oral LD_{50} in dogs is considered to be in excess of 50 mg/kg, while lethality was seen in monkeys at 360 mg/kg. The toxic dose in man is not known, but blood levels in excess of 800 ng/ml have not been associated with toxicity.

DOSAGE AND ADMINISTRATION

Exertional Angina Pectoris Due to Atherosclerotic Coronary Artery Disease or Angina Pectoris at Rest Due to Coronary Artery Spasm. Dosage must be adjusted to each patient's needs. Starting with 30 mg four times daily, before meals and at bedtime, dosage should be increased gradually (given in divided doses three or four times daily) at one- to two-day intervals until optimum response is obtained. Although individual patients may respond to any dosage level, the average optimum dosage range appears to be 180 to 240 mg/day. There are no available data concerning dosage requirements in patients with impaired renal or hepatic function. If the drug must be used in such patients, titration should be carried out with particular caution.

Concomitant Use With Other Antianginal Agents:

1. **Sublingual NTG** may be taken as required to abort acute anginal attacks during CARDIZEM therapy.
2. **Prophylactic Nitrate Therapy**—CARDIZEM may be safely coadministered with short- and long-acting nitrates, but there have been no controlled studies to evaluate the antianginal effectiveness of this combination.
3. **Beta-blockers.** (See WARNINGS and PRECAUTIONS.)

HOW SUPPLIED

Cardizem 30-mg tablets are supplied in bottles of 100 (NDC 0088-1771-47) and in Unit Dose Identification Paks of 100 (NDC 0088-1771-49). Each green tablet is engraved with MARION on one side and 1771 engraved on the other. CARDIZEM 60-mg scored tablets are supplied in bottles of 100 (NDC 0088-1772-47) and in Unit Dose Identification Paks of 100 (NDC 0088-1772-49). Each yellow tablet is engraved with MARION on one side and 1772 on the other.

Issued 4/1/84

Another patient benefit product from

PHARMACEUTICAL DIVISION
MARION LABORATORIES, INC.
KANSAS CITY, MISSOURI 64137

BALANCED CALCIUM CHANNEL BLOCKADE!



Low incidence of side effects
CARDIZEM® (diltiazem HCl) produces an incidence of adverse reactions not greater than that reported with placebo therapy, thus contributing to the patient's sense of well-being.

*Cardizem is indicated in the treatment of angina pectoris due to coronary artery spasm and in the management of chronic stable angina (classic effort-associated angina) in patients who cannot tolerate therapy with beta-blockers and/or nitrates or who remain symptomatic despite adequate doses of these agents.

References:
1. Strauss WE, McIntyre KM, Parisi AF, et al: Safety and efficacy of diltiazem hydrochloride for the treatment of stable angina pectoris: Report of a cooperative clinical trial. Am J Cardiol 49:560-566, 1982.
2. Pool PE, Seagren SC, Bonanno JA, et al: The treatment of exercise-inducible chronic stable angina with diltiazem: Effect on treadmill exercise. Chest 78 (July suppl):234-238, 1980.

Reduces angina attack frequency*
42% to 46% decrease reported in multicenter study.[1]

Increases exercise tolerance*
In Bruce exercise test,[2] control patients averaged 8.0 minutes to onset of pain; Cardizem patients averaged 9.8 minutes ($P<.005$).

CARDIZEM®
(diltiazem HCl)

THE BALANCED CALCIUM CHANNEL BLOCKER

Please see full prescribing information on following page.

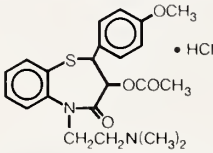
2/84

PROFESSIONAL USE INFORMATION

cardizem®
(diltiazem HCl)
30 mg and 60 mg tablets

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3. **Beta-blockers.** (See WARNINGS and PRECAUTIONS.)

HOW SUPPLIED

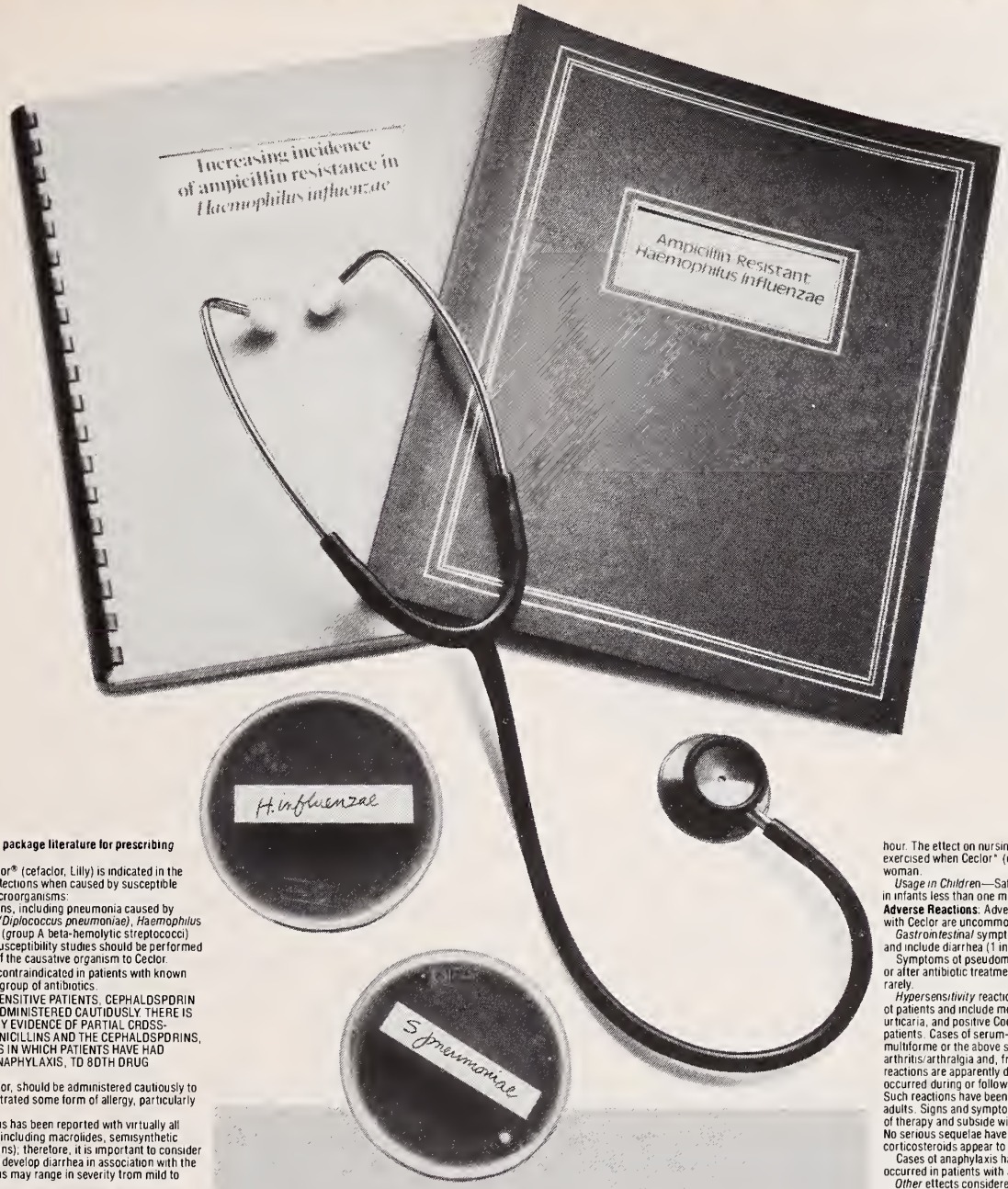
Cardizem 30-mg tablets are supplied in bottles of 100 (NOC 0088-1771-47) and in Unit Oose Identification Paks of 100 (NOC 0088-1771-49). Each green tablet is engraved with MARION on one side and 1771 engraved on the other. CARDIZEM 60-mg scored tablets are supplied in bottles of 100 (NOC 0088-1772-47) and in Unit Oose Identification Paks of 100 (NOC 0088-1772-49). Each yellow tablet is engraved with MARION on one side and 1772 on the other.

Issued 4/1/84

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KANSAS CITY, MISSOURI 64137

An added complication... in the treatment of bacterial bronchitis*



Some ampicillin-resistant strains of Haemophilus influenzae—a recognized complication of bacterial bronchitis*—are sensitive to treatment with Ceclor.[1-6]

In clinical trials, patients with bacterial bronchitis due to susceptible strains of Streptococcus pneumoniae, H. influenzae, S. pyogenes (group A beta-hemolytic streptococci), or multiple organisms achieved a satisfactory clinical response with Ceclor.[7]

Ceclor®
cefaclor
Pulvules®, 250 and 500 mg

Brief Summary. Consult the package literature for prescribing information.

Indications and Usage: Ceclor® (cefaclor, Lilly) is indicated in the treatment of the following infections when caused by susceptible strains of the designated microorganisms:

Lower respiratory infections, including pneumonia caused by *Streptococcus pneumoniae (Diplococcus pneumoniae), Haemophilus influenzae,* and *S. pyogenes* (group A beta-hemolytic streptococci)

Appropriate culture and susceptibility studies should be performed to determine susceptibility of the causative organism to Ceclor.

Contraindication: Ceclor is contraindicated in patients with known allergy to the cephalosporin group of antibiotics.

Warnings: IN PENICILLIN-SENSITIVE PATIENTS, CEPHALOSPORIN ANTIBIOTICS SHOULD BE ADMINISTERED CAUTIOUSLY. THERE IS CLINICAL AND LABORATORY EVIDENCE OF PARTIAL CROSS-ALLERGENICITY OF THE PENICILLINS AND THE CEPHALOSPORINS, AND THERE ARE INSTANCES IN WHICH PATIENTS HAVE HAD REACTIONS, INCLUDING ANAPHYLAXIS, TO BOTH DRUG CLASSES.

Antibiotics, including Ceclor, should be administered cautiously to any patient who has demonstrated some form of allergy, particularly to drugs.

Pseudomembranous colitis has been reported with virtually all broad-spectrum antibiotics (including macrolides, semisynthetic penicillins, and cephalosporins); therefore, it is important to consider its diagnosis in patients who develop diarrhea in association with the use of antibiotics. Such colitis may range in severity from mild to life-threatening.

Treatment with broad-spectrum antibiotics alters the normal flora of the colon and may permit overgrowth of clostridia. Studies indicate that a toxin produced by *Clostridium difficile* is one primary cause of antibiotic-associated colitis.

Mild cases of pseudomembranous colitis usually respond to drug discontinuance alone. In moderate to severe cases, management should include sigmoidoscopy, appropriate bacteriologic studies, and fluid, electrolyte, and protein supplementation. When the colitis does not improve after the drug has been discontinued, or when it is severe, oral vancomycin is the drug of choice for antibiotic-associated pseudomembranous colitis produced by *C. difficile.* Other causes of colitis should be ruled out.

Precautions: *General Precautions*—If an allergic reaction to Ceclor occurs, the drug should be discontinued, and, if necessary, the patient should be treated with appropriate agents, e.g., pressor amines, antihistamines, or corticosteroids.

Prolonged use of Ceclor may result in the overgrowth of nonsusceptible organisms. Careful observation of the patient is essential. If superinfection occurs during therapy, appropriate measures should be taken.

Positive direct Coombs' tests have been reported during treatment with the cephalosporin antibiotics. In hematologic studies or in transfusion cross-matching procedures when antiglobulin tests are performed on the minor side or in Coombs' testing of newborns whose mothers have received cephalosporin antibiotics before parturition, it should be recognized that a positive Coombs' test may be due to the drug.

Ceclor should be administered with caution in the presence of markedly impaired renal function. Under such conditions, careful clinical observation and laboratory studies should be made because safe dosage may be lower than that usually recommended.

As a result of administration of Ceclor, a false-positive reaction for glucose in the urine may occur. This has been observed with Benedict's and Fehling's solutions and also with Clinitest® tablets but not with Tes-Tape® (Glucose Enzymatic Test Strip, USP, Lilly).

Broad-spectrum antibiotics should be prescribed with caution in individuals with a history of gastrointestinal disease, particularly colitis.

Usage in Pregnancy—Pregnancy Category B—Reproduction studies have been performed in mice and rats at doses up to 12 times the human dose and in ferrets given three times the maximum human dose and have revealed no evidence of impaired fertility or harm to the fetus due to Ceclor. There are, however, no adequate and well-controlled studies in pregnant women. Because animal reproduction studies are not always predictive of human response, this drug should be used during pregnancy only if clearly needed.

Nursing Mothers—Small amounts of Ceclor have been detected in mother's milk following administration of single 500-mg doses. Average levels were 0.18, 0.20, 0.21, and 0.16 mcg/ml at two, three, four, and five hours respectively. Trace amounts were detected at one hour. The effect on nursing infants is not known. Caution should be exercised when Ceclor* (cefaclor, Lilly) is administered to a nursing woman.

Usage in Children—Safety and effectiveness of this product for use in infants less than one month of age have not been established.

Adverse Reactions: Adverse effects considered related to therapy with Ceclor are uncommon and are listed below:

Gastrointestinal symptoms occur in about 2.5 percent of patients and include diarrhea (1 in 70).

Symptoms of pseudomembranous colitis may appear either during or after antibiotic treatment. Nausea and vomiting have been reported rarely.

Hypersensitivity reactions have been reported in about 1.5 percent of patients and include morbilliform eruptions (1 in 100). Pruritus, urticaria, and positive Coombs' tests each occur in less than 1 in 200 patients. Cases of serum-sickness-like reactions (erythema multiforme or the above skin manifestations accompanied by arthritis/arthralgia and, frequently, fever) have been reported. These reactions are apparently due to hypersensitivity and have usually occurred during or following a second course of therapy with Ceclor. Such reactions have been reported more frequently in children than in adults. Signs and symptoms usually occur a few days after initiation of therapy and subside within a few days after cessation of therapy. No serious sequelae have been reported. Antihistamines and corticosteroids appear to enhance resolution of the syndrome.

Cases of anaphylaxis have been reported, half of which have occurred in patients with a history of penicillin allergy.

Other effects considered related to therapy included eosinophilia (1 in 50 patients) and genital pruritus or vaginitis (less than 1 in 100 patients).

Causal Relationship Uncertain—Transitory abnormalities in clinical laboratory test results have been reported. Although they were of uncertain etiology, they are listed below to serve as alerting information for the physician.

Hepatic—Slight elevations of SGDT, SGPT, or alkaline phosphatase values (1 in 40).

Hematopoietic—Transient fluctuations in leukocyte count, predominantly lymphocytosis occurring in infants and young children (1 in 40).

Renal—Slight elevations in BUN or serum creatinine (less than 1 in 500) or abnormal urinalysis (less than 1 in 200).

[061782R]

*Many authorities attribute acute infectious exacerbation of chronic bronchitis to either *S. pneumoniae* or *H. influenzae.* *

Note: Ceclor is contraindicated in patients with known allergy to the cephalosporins and should be given cautiously to penicillin-allergic patients.

Penicillin is the usual drug of choice in the treatment and prevention of streptococcal infections, including the prophylaxis of rheumatic fever. See prescribing information.

References

1. Antimicrob. Agents Chemother., *8*:91, 1975.
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7. Data on file, Eli Lilly and Company.
8. Principles and Practice of Infectious Diseases (edited by G.L. Mandell, R.G. Douglas, Jr., and J.E. Bennett), p. 487. New York: John Wiley & Sons, 1979.

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Additional information available to the profession on request from Eli Lilly and Company, Indianapolis, Indiana 46285.

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president's letter



Georgians Lead the AMA

THESE ARE EXCITING TIMES to be a part of the Georgia delegation to the American Medical Association. At the recent Annual Session of the AMA House of Delegates, Dr. Harrison L. (Jack) Rogers, Jr., of Atlanta, ran unopposed for the office of President-Elect and was elected by acclamation. This is the first time in many years that a Georgian has served in this capacity. Jack was an effective and popular Vice-Speaker and Speaker of the MAG House of Delegates and went on to be elected Vice-Speaker and subsequently Speaker of the AMA House of Delegates. The caliber of his leadership there assured that he would not have opposition in his race for the highest elected medical office in the nation. In this capacity, he will be the "Voice of Medicine" before the top medical, governmental, business and civic organizations, and the general public.

Jack's election came about during the same annual session where our own Glenda Bates (Mrs. John) of Cuthbert was completing a term as President of the Auxiliary to the American Medical Association. Glenda had been State President of the Auxiliary to the MAG as well as active on the national level before being elected, without opposition, to the office of President-Elect of the AMA Auxiliary in 1982. This charming lady has traveled the length and breadth of America in a labor of love leading this supportive branch of medicine.

Having presidents for both national organizations come from Georgia and serve in such close tandem is really something. Glenda and Jack do us proud!

There are other voices from Georgia which cannot be ignored at the AMA. Dr. Bill Dowda from Atlanta has been such an active participant in the deliberations of the AMA House that one floor microphone has been designated as the "Dowda microphone." Bill's leadership was so outstanding at the AMA that he was elected, in his first race, to the AMA Board of Trustees, the policy making body of the AMA.

Dr. Dan Bateman from Albany serves with distinction on the AMPAC Board of Directors.

Georgians can be proud also of other members of the Georgia delegation all of whom are past presidents of the MAG: C. Emory Bohler, of Brooklet, Chairman of the delegation; H. Hilt Hammett, of LaGrange; Charles D. Hollis, of Albany; Carson B. "Bucky" Burgstiner, of Savannah; and William W. Moore and L. Newton Turk, both of Atlanta. Your AMA delegation is a working group whose day usually begins with a 6:30 AM breakfast caucus and ends late at night. Success at the AMA has been due to hard work by quality leaders, not by quantity of delegates.

When Georgians attain such positions of leadership at the AMA it bears out the old saying, "The cream rises to the top." We all can be proud to be from Georgia.

S. William Clark

S. William Clark, Jr., M.D.

the association
the association
the association

NEW MEMBERS

Atkins, Kenney S., Blue Ridge—ACT (N-2)—GP
7 Main St., McCaysville 30555

Ayers, Gary R., MAA—ACT (N-2)—TR
1000 Johnson Ferry Rd., NE, Atlanta 30342

Bakay, Roy A. E., DeKalb—ACT—GS/NS
1365 Clifton Rd., NE, Atlanta 30322

Blackwell, J. Thomas, Jr., Georgia Medical Society—ACT—(N-2)—AN
515 E. 63rd St., Savannah 31410

Blalock, C. Phillip, Bibb—ACT (N-2)—R
Dept. of Radiology, Middle Georgia Hospital, Macon 31201

Blank, Stephen C., MAA—ACT—OBG
315 Boulevard, NE, Ste. 328, Atlanta 30312

Boling, Barbara E., MAA—ACT (N-1)—IM
3810 Pleasantdale Rd., Atlanta 30340

Collins, William T., Jr., DeKalb—ACT (N-2)—GP
1462 Montreal Rd., Ste. 212, Tucker 30084

Crosse, James E. W., Muscogee—Service—U
Urology Service, Martin Army Community Hospital, Fort Benning 31905

Curl, Walton W., Muscogee—ACT (N-2)—ORS
6262 Hamilton Rd., Columbus 31995

Curling, Patrick E., MAA—ACT
1364 Clifton Rd., NE, Atlanta 30322

Cuttino, Judson P., Georgia Medical Society—ACT (N-2)—AN
8 Stephenson Ave., Savannah 31406

Engel, Nancy L., MAA—ACT (N-2)—P
2905 Peachtree Rd., NE, Atlanta 30363

Ewing, Douglas E., Richmond—ACT (N-2)—P
2350 Washington Rd., Augusta 30904

Hanafi, Magdi M., Cobb—ACT—OBG
Dept. of OB/GYN, 300 Boulevard, NE, Atlanta 30312

Hillard, Katharine A., MAA—I&R—P
1884 Ridgewood Dr., NE, Atlanta 30307

Malone, Patrick T., MAA—ACT—P
6363 Roswell Rd., NE, Atlanta 30328

Mendez, Ruben A., Cobb—ACT—P/CHP
3985 S. Cobb Dr., Smyrna 30080

Mork, Virginia C., MAA—I&R
Grady Memorial Hospital, Atlanta 30303

Morris, Thomas W., Muscogee—ACT—FP
P. O. Box 749, Eatonton 31024

Powers, Robert W., MAA—ACT
105 Collier Rd., NW, Ste 1020, Atlanta 30309

Ramaiya, Nalini K., Bibb—I&R—FP
Dept. of Family Practice, Medical Center of Central Georgia, Macon 31210

Shanik, Edward J., MAA—ACT—FP
1585 Holcomb Bridge Rd., Roswell 30076

Sharon, Zeev, DeKalb—ACT—IM/NEP
497 Winn Way, Ste. A-210, Decatur 30030

Steinberg, James P., MAA—ACT (N-2)—IM
1297 Oakdale Rd., Atlanta 30307

Steiner, Albin H., Sumter—ACT—R
701 E. Lamar St., Americus 31709

Stoudemire, G. Alan, MAA—ACT—P
Duke University Medical Center, Box 3903, Durham, NC 27710

Tkalych, George P., Muscogee—ACT—OTO—HNS
2039 Tenth Ave., Columbus 31901

Verras, Athanasios, DeKalb—ACT (N-2)—PD
2100 Parklake Dr., NE, Ste. 3, Atlanta 30345

Wessinger, William N., Georgia Medical Society—ACT—ORS/HS
800 E. 70th St., P. O. Box 22787, Savannah 31405

Williamson, C. Davis, Baldwin—ACT (N-2)—OPH
540-A W. Thomas St., Milledgeville 31061

Yalamanchili, Gandhiji, Dougherty—ACT—IM/GE
1009 N. Monroe St., Ste. 107, Albany 31701

Wilds, Benjamin J., South Georgia—Service—PD
Moody Air Force Base, Valdosta 31601

PERSONALS

Fifth District

J. Willis Hurst, M.D., Candler Professor of Medicine and Chairman of the Department of Medicine at Emory University School of Medicine, has been given the Medical College of Georgia Alumni Association Distinguished Alumni Award. He is only the second alumnus to receive this award, designed to "recognize and honor men and women who have lived lives of distinction.

eminence, and excellence.'' Dr. Hurst is most widely recognized among generations of physicians as a master teacher and editor of *The Heart,* a widely used textbook. He also edited the recently published textbook, *Medicine for the Practicing Physician,* which won the best book of the year in its category, an award given by the Association of American Publishers. He has held many positions of leadership, including presidency of the American Heart Association and, currently, presidency of the Association of Professors of Medicine.

Atlanta physician, **John Leonardy, M.D.,** was installed as president of the American College of Allergists during the group's national conference in April.



Louis W. Sullivan

Louis W. Sullivan, M.D., president and dean of the Morehouse School of Medicine, is the 1984 recipient of the Distinguished Achievement Award from the Center Alumni Council of the New York Hospital-Cornell Medical Center. Dr. Sullivan was cited as ''a physician and clinical investigator of prominence, an educator of distinction, and a national leader in the development of educational opportunities in medicine'' during ceremonies at the annual alumni banquet at Cornell.

Seventh District

Arthur Butterfield, M.D., has opened a new office near Gordon Hospital in Calhoun for the practice of obstetrics and gynecology.

Smyrna physician, **John S. Carman, M.D.,** director of research for the Smyrna-based Center for Interpersonal Studies, P.A., has been nominated to serve as Citizens Ambassador to the Republic of China. As an expert in the biology of mood disorders, he has also been invited to join a group of his American colleagues in touring several Chinese cities this fall. Dr. Carman has earned two prestigious international awards for clinical research in the field of psychopharmacology. He has published more than 100 articles, book chapters and national presentations and coedited a book entitled *Advances in Psychopharmacology: Predicting and Improving Treatment Response*. Most recently, he authored an abstract accepted for presentation in July at the 15th International Congress of the International Society of Psychoneuroendocrinology in Vienna.

Ninth District

Paul Behrmann, M.D., has opened a private family practice in Dawsonville. Dr. Behrmann has served on the Dawson County National Health Service Corps Board for the past 6 years. He will be the first private practicing physician in Dawsonville in many years.

Martin Smith, M.D., of Gainesville, has been elected president-elect of the American Academy of Pediatrics. He is the first Georgian and first pediatrician from a small city to be elected to this position.

George T. Nicholson, M.D., from Cornelia, retired in July after 40 years of family practice. Dr. Nicholson graduated from MCG in 1943 and was a Fellow of the American Academy of Family Practice. He served for many years with MAG and chaired the Rural Health Committee.

DEATHS

William Clifton Calhoun

William Clifton Calhoun, M.D., died June 12.

After receiving his medical degree from the Medical College of Georgia, Dr. Calhoun served in the U.S. Navy at Bainbridge, Maryland, and at the University Hospital in Baltimore where he interned. During World War II, Dr. Calhoun served as battalion surgeon with the 12th Marines at Iwo Jima and Guam and as battalion surgeon with the Seabees in Tsingtao, China.

Dr. Calhoun is survived by his wife, three daughters, one son, two sisters, one brother, and six grandchildren.

James Elmo Yarbrough

James Elmo Yarbrough, M.D., 84, of Columbus, died June 16. Dr. Yarbrough was a veteran of World War II and the Korean War. He was a retired colonel and physician of the U.S. Army.

Survivors include his wife and one son.



Committee Activities . . .

Highlights — MAG Executive Committee Meeting, June 1984

The regular monthly meeting of the Executive Committee (EC) of the Medical Association of Georgia convened on June 8, 1984, in Rome, Georgia. The following are highlights of that meeting.

Constitution and Bylaws Committee — The Constitution and Bylaws Committee brought to the attention of the EC that an amendment to Bylaws Chapter XI, Section 2, Subsection C, *Dues and Assessments,* was inadvertently left out of the Reference Committee Report to the House. This amendment called for the repealing of the 1-year's dues in arrears payment for those physicians who had dropped out of MAG for a year and returned the next year. The EC agreed to allow staff to handle this matter administratively in order that MAG membership would not be encumbered.

***Atlanta Journal* Advertisement —** In a letter from past president Dr. Moore, a complaint was registered regarding an advertisement in the Atlanta paper that was misleading and fraudulent. Following discussion, the EC requested to investigate the person and matter and, in turn, report the matter to the Composite State Board of Medical Examiners.

Jeffrey T. Nugent Letter — In a letter from Dr.Nugent, President of the Medical Association of Atlanta, the EC was requested to investigate the matter of supporting the Committee on Aging in their quest to seek adequate medical service for monies expended. The Chair requested the MAG Medical Practice Committee to study Dr. Nugent's document and prepare an adequate response.

Composite State Board of Medical Examiners (CSBME) Nominees — The EC voted to submit for nomination Thomas J. Busey, M.D., urologist, Fayetteville, representing the Sixth District; and Eloise B. Sherman, M.D., pathologist, Savannah, representing the First District, to serve on the CSBME beginning Sept. 1, 1984.

Blue Cross/Blue Shield PPO — The May EC voted to inform the MAG membership of the Blue Cross/Blue Shield PPO plan including those portions of the contract which may have legal significance, in order for them to better consider this plan. It was emphasized that this should be reaffirmation of the Association's previous action in providing information to its members regarding contractual practice arrangements. The Executive Director reported that a letter, as well as legal counsel's review of the PPO contract, had been prepared to be sent to MAG membership. It was understood that the President and Executive Director would review the letter and include all points that were discussed at this meeting.

Highlights — MAG Board of Directors Meeting, June 9, 1984

The quarterly meeting of the MAG Board of Directors was called to order by the Chairman, Joe L. Nettles, M.D., on June 9, 1984, in Rome, Georgia. Following are the highlights of that meeting:

Auxiliary — The President of the MAG Auxiliary gave a presentation to the Board regarding the Auxiliary's activities for the coming year. Some of those reported are: Community Plans for Drug Abuse Prevention; the Auxiliary Learning Center; Assisting MAG with Child Abuse Prevention Project, Infant Mortality Plan with MAG, the Impaired Physicians Project with MAG, membership recruitment; the William R. Dancy Student Loan Fund; and the Communications Workshop.

Maternal and Infant Health Task Force — In a memorandum from the chairman of the Maternal and Infant (M&I) Health Committee, the MAG Board was requested to financially assist the M&I Health Committee in a research project to develop lists of services that are available in each county of the state. The Board allocated a maximum of $1200 for a research assistant to develop this information.

Resolution: Use of AMA Scientific Reports in Professional Liability Suits — MAG Mutual requested MAG's endorsement of a resolution regarding a recent Council Report on "Early Detection of Breast Cancer" (I-83) recommending annual mammography for all women aged 50 or older. There was some discussion regarding a disclaimer to this resolution. Following discussion, it was the consensus of the Board (12 for, 7 against) to approve the resolution to be submitted to the AMA House of Delegates. It was understood by the Board that the resolution would be distributed to MAG delegates and alternates with direction that MAG is in favor of the disclaimer.

Impaired Physicians Committee — The Medical Director of the Impaired Physicians Program gave an update on the impaired physicians research project which was authorized by the Board in January. It was stated that monies from MAG Mutual were forthcoming to help with the financial aspects of the project and a proposal to the AMA-ERF for a grant of $25,000 was solicited and subsequently approved by the AMA at its June meeting.

The Georgia Medical Care Foundation — The Executive Director of GMCF reported that the Foundation met the requirements of the PRO Contract and is now in the process of negotiation. The MAG computer system is expected to be set up in time.

MAG Mutual Insurance Company — It was reported that MAG Mutual would be moving their office to another building; MAG Mutual is still anticipating that they and MAG will occupy the same building some time in the future. There have been no major settlements since the last Board meeting.

MAG Leadership Conference — The MAG Leadership conference will be held at the Waverly Hotel, Atlanta, on February 1-2, 1985. Plans for this Conference include: MAG hosting a luncheon for the county medical society presidents; tentatively planning a registration fee $50 for members; $150 for non-members; and $50 for residents (giving them 1-year free membership in MAG.

A WORD TO THE WHYS

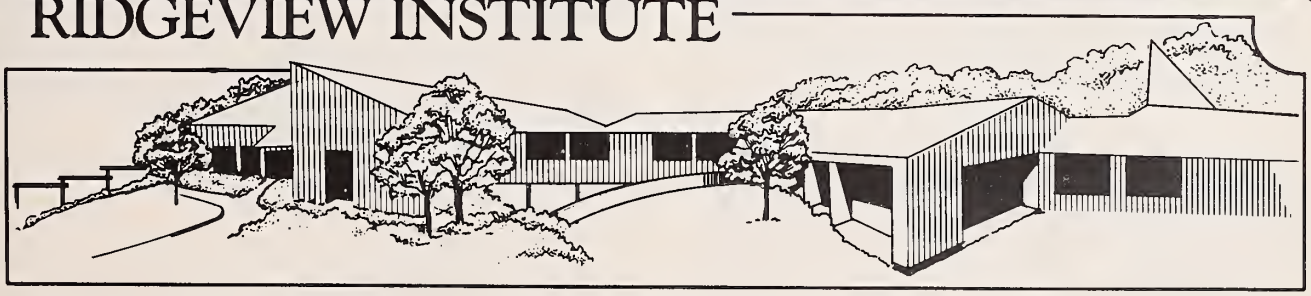
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1000 Square Feet Medical/Dental Office for rent/lease in new medical building near hospital in Riverdale. Will decorate to suit taste. Terms negotiable. Call (404) 991-1616 during office hours.

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Journals Wanted. Need immediately about 10-20 recent years of neatly bound medical journals to fill and dress up office shelves. Prefer JAMA, or NEJN, but will consider others of general interest. Send details and asking price to: Dr. Leslie Norins, 67 Peachtree Park Dr., Atlanta, GA 30309. Office Phone: (404) 351-4523.

SITUATION WANTED

Highly qualified Japanese acupuncturist, new to Atlanta, 33-years-old, seeks association with U. S. medical doctor who is interested in acupuncture. Contact Mr. Takashi Yoshida, 500 Rock Springs Rd., NE, Atlanta, GA 30324. Ph:404/881-0819.

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STYLE — Ordinarily articles should not exceed 3,000 words. Only under exceptional circumstances will articles of over 4,000 words be published. Footnotes, bibliographies, and legends should be typed on separate sheets, double-spaced. Bibliographies should conform to the following style: name of author (with initials), title of article, name of periodical, date, volume (number, if available), and pages.

> Soter NA, Wasserman SI, Austen KF. Cold urticaria release into circulation of histamine and eosinophil chemotactic factor of anaphylaxis during cold challenge. N Engl J Med 1976;294:687-90.

NEWS NOTES — District and county medical societies, Association members, and readers are invited to send in any news items of general concern to members of the Medical Association of Georgia.

REPRINTS — Requests for reprints should be made directly to The Ovid Bell Press, Inc., 1201-05 Bluff Street, Fulton, Missouri 65251. Reprints must be ordered within 30 days after publication, since all type will be destroyed after that time.

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Your patient's illness doesn't have to be psychosomatic to be all in the head

We've all seen them. Patient's who continually manifest physical conditions that we know have underlying emotional or mental causes. The physical ailments are real, all right. But eventually, it's clear that something more must be done to effectively treat the patient.

Sometimes drug therapy on an outpatient basis from our own offices is enough. Sometimes it's not.

When comprehensive treatment for mental health problems is indicated, Charter By-the-Sea Hospital on St. Simons Island can help. Their short-term inpatient program provides specialized care for persons suffering from depression, anxiety, schizophrenia, manic-depressive illness, personality disorders, psycho-physiologic disorders and other dysfunctions.

Upon admission, clinical assessment includes an analysis of the patient's psychological, physical, social, family, cultural and recreational needs. A treatment team of skilled and caring physicians, nurses, social workers, psychologists, mental health assistants, recreational therapists and other clinical professionals design an individualized treatment plan.

Charter By-the-Sea also has a separate, medically-supervised, AA-based addictive disease unit for treatment of drug and alcohol dependency. The resources of this unit are available to mental health patients if necessary.

And because the hospital is JCAH accredited and fully licensed, most major hospitalization insurance plans cover treatment.

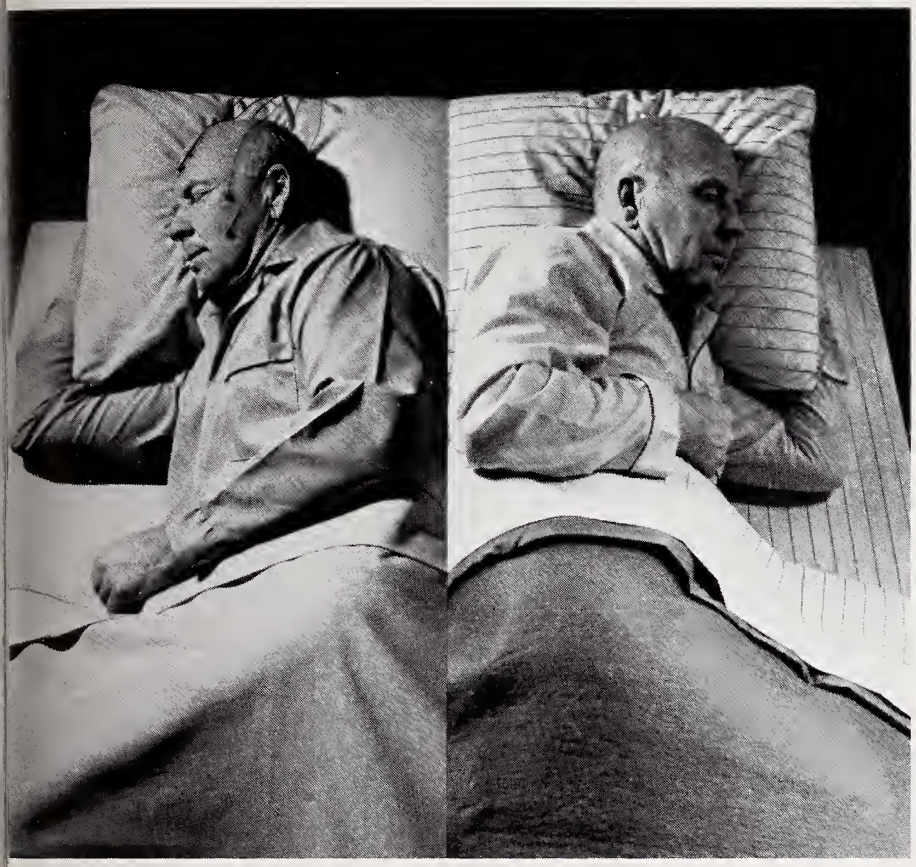
If you have a patient who may need psychiatric hospitalization, call toll free. Our medical director, Roger Jay Pentzien, M.D., is available 24 hours to take your call.

Charter By-the-Sea

St. Simons Island, Georgia

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References: 1. Kales J *et al*: *Clin Pharmacol Ther 12*:691-697, Jul-Aug 1971. **2.** Kales A *et al*: *Clin Pharmacol Ther 18*:356-363, Sep 1975. **3.** Kales A *et al*: *Clin Pharmacol Ther 19*:576-583, May 1976. **4.** Kales A *et al*: *Clin Pharmacol Ther 32*:781-788, Dec 1982. **5.** Frost JD Jr, DeLucchi MR: *J Am Genatr Soc* 27:541-546, Dec 1979. **6.** Kales A, Kales JD: *J Clin Pharmacol 3*:140-150, Apr 1983. **7.** Greenblatt DJ, Allen MD, Shader RI: *Clin Pharmacol Ther 21*:355-361, Mar 1977. **8.** Zimmerman AM: *Curr Ther Res 13*:18-22, Jan 1971. **9.** Amrein R *et al*: *Drugs Exp Clin Res 9*(1):85-99, 1983. **10.** Monti JM: *Methods Find Exp Clin Pharmacol 3*:303-326, May 1981. **11.** Greenblatt DJ *et al*: *Sleep 5*(Suppl 1):S18-S27, 1982. **12.** Kales A *et al*: *Pharmacology 26*:121-137, 1983.

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Before prescribing, please consult complete product information, a summary of which follows:

Indications: Effective in all types of insomnia characterized by difficulty in falling asleep, frequent nocturnal awakenings and/or early morning awakening, in patients with recurring insomnia or poor sleeping habits; in acute or chronic medical situations requiring restful sleep. Objective sleep laboratory data have shown effectiveness for at least 28 consecutive nights of administration. Since insomnia is often transient and intermittent, prolonged administration is generally not necessary or recommended. Repeated therapy should only be undertaken with appropriate patient evaluation.

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Precautions: In elderly and debilitated patients, it is recommended that the dosage be limited to 15 mg to reduce risk of oversedation, dizziness, confusion and/or ataxia. Consider potential additive effects with other hypnotics or CNS depressants. Employ usual precautions in severely depressed patients, or in those with latent depression or suicidal tendencies, or in those with impaired renal or hepatic function.

Adverse Reactions: Dizziness, drowsiness, lightheadedness, staggering, ataxia and falling have occurred, particularly in elderly or debilitated patients. Severe sedation, lethargy, disorientation and coma, probably indicative of drug intolerance or overdosage, have been reported. Also reported: headache, heartburn, upset stomach, nausea, vomiting, diarrhea, constipation, GI pain, nervousness, talkativeness, apprehension, irritability, weakness, palpitations, chest pains, body and joint pains and GU complaints. There have also been rare occurrences of leukopenia, granulocytopenia, sweating, flushes, difficulty in focusing, blurred vision, burning eyes, faintness, hypotension, shortness of breath, pruritus, skin rash, dry mouth, bitter taste, excessive salivation, anorexia, euphoria, depression, slurred speech, confusion, restlessness, hallucinations, and elevated SGOT, SGPT, total and direct bilirubins, and alkaline phosphatase; and paradoxical reactions, *e.g.*, excitement, stimulation and hyperactivity.

Dosage: Individualize for maximum beneficial effect. *Adults:* 30 mg usual dosage; 15 mg may suffice in some patients. *Elderly or debilitated patients:* 15 mg recommended initially until response is determined.

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JOURNAL
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SEPTEMBER/1984



November 16-18

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Program Highlights and Registration Form Inside



Your patient's illness doesn't have to be psychosomatic to be all in the head

We've all seen them. Patient's who continually manifest physical conditions that we know have underlying emotional or mental causes. The physical ailments are real, all right. But eventually, it's clear that something more must be done to effectively treat the patient.

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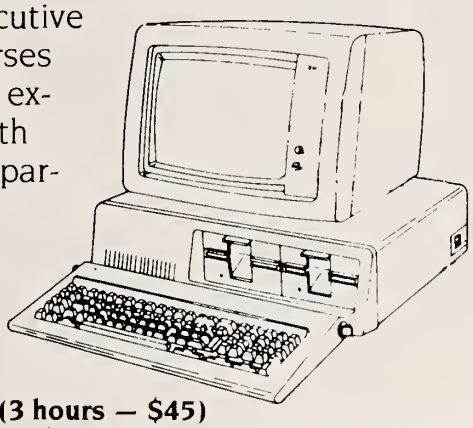
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Designed for health professionals with limited computer experience. This workshop introduces basic concepts to help you decide where you need to go next. A hands-on overview of available software.

Thursday evening, October 18	6:30 to 9:30
Saturday morning, October 20	9:00 to 12:00

The IBM PC/XT and the MS-DOS Operating System (3 hours — $45)
A look inside the IBM Personal Computer and its operation. Learning to keep track of your files (making directories, copying files, formatting diskettes, etc.) using MS-DOS.

Thursday evening, October 11	6:30 to 9:30
Saturday afternoon, October 20	1:30 to 4:30

Beginning LOTUS 1-2-3 (7 hours — $100)
Learn how to set up budgets and other financial models using the spreadsheet functions of this powerful software. With these models you can do your own "what-if" forecasting and planning.

All day Thursday, October 18	8:30 to 4:30
Two Tuesday evenings, October 16 and 23	6:30 to 10:00
All day Saturday, October 27	8:30 to 4:30

Advanced LOTUS 1-2-3 (7 hours — $100)
Explore Lotus's other capabilities — database management, graph production, and programming (with "macros"). Beginning Lotus is a prerequisite.

All day Sunday, October 28	8:30 to 4:30

dBASE II (7 hours — $100)
This database manager allows you to set up files (such as patient information) and then sort or search those files on the basis of various criteria. A powerful record management tool

All day Wednesday, October 17	8:30 to 4:30
All day Sunday, October 21	8:30 to 4:30

WordStar (7 hours — $100)
Learn to use this popular word processor to enter and modify text, then print out a letter-perfect document.

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All day Thursday, October 25	8:30 to 4:30

Volkswriter Deluxe (4 hours — $65)
An easy-to-learn word processor with powerful features.

Wednesday afternoon, October 10	1:00 to 5:00
Wednesday evening, October 17	6:00 to 10:00

For reservations and information call Barry Lastinger, Director of Education at (404) 325-2441.

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Established 1911. Owned and edited by the Medical Association of Georgia. Published monthly under the direction of the Board of Directors of the Association. Printed by The Ovid Bell Press, Inc., Fulton, Missouri.

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The subscription price per year for members of the Medical Association of Georgia is $7.50, included in the annual membership dues. The subscription price for nonmembers is $15.00 in the United States, Canada and Mexico, and $17.00 in other countries. Single copies are $2.

The *Journal of the Medical Association of Georgia* is published monthly at 938 Peachtree Street, N. E., Atlanta, GA 30309-3990. Second-class postage paid at Atlanta, Georgia, and at additional mailing offices. POSTMASTER: Send address changes to Medical Association of Georgia, 938 Peachtree Street, N. E., Atlanta, GA 30309-3990.

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MAG Scientific Assembly 1984

Specialty societies come together.
MAG handles the details.
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The MAG Scientific Assembly

November 16-18

RITZ-CARLTON BUCKHEAD HOTEL

Atlanta

Georgia's premier forum for specialty society medical education.

Contact MAG in Atlanta (404) 876-7535 / 1-800-282-0224 toll free in Georgia

A brief look at our Scientific Assembly, scheduled for November 16-18 at the Ritz-Carlton Buckhead Hotel in Atlanta. The complete program will appear in next month's **Journal.**

The MAG Scientific Assembly — Georgia's Premier Forum For Specialty Society Education

ELLIS B. KEENER, M.D., ***Gainesville****

"SPECIALTY SOCIETIES come together. MAG handles the details. You get the rewards."

That's the way our Scientific Assembly has worked, and it seems to be working well. Our format allows state specialty societies to select the educational topics and speakers preferred by them. The staff of the MAG coordinates publicity and registration and makes arrangements for meeting rooms, audiovisual needs, coffee breaks, etc. From registration fees received, the MAG in turn helps societies pay for their speakers.

This fall, the Scientific Assembly of the Medical Association of Georgia will meet in Atlanta at the Ritz-Carlton Buckhead Hotel. Our scheduled dates are November 16-18 (Friday-Sunday). Eleven specialty programs will be presented during the weekend, each of which will be accredited for AMA Category I hours and other specialty credit designations.

Specialty Societies Participating in this Year's Scientific Assembly

Allergy: Allergy and Immunology Society of Georgia
Program Chairman: Thomas F. Smith, M.D., Atlanta

Chest Disease: Georgia Thoracic Society
Program Chairman: Paul Scheinberg, M.D., Atlanta

Georgia Chapter, American College of Chest Physicians
Program Chairman: Ralph L. Haynes, M.D., Atlanta

Emergency Medicine: Georgia Chapter, American College of Emergency Physicians
Program Chairman: Gail Anderson, M.D., Atlanta

Gastroenterology: Georgia Gastroenterologic Society
Program Chairman: Paul R. Rodzewicz, M.D., Atlanta

Neurology: Georgia Neurological Society
Program Chairman: Mark A. Kozinn, M.D., East Point

Neurosurgery: Georgia Neurosurgical Society
Program Chairman: Fleming L. Jolley, M.D., Brunswick

Otolaryngology: Georgia Society of Otolaryngology/Head and Neck Surgery
Program Chairman: William E. Silver, M.D., Atlanta

Greater Atlanta Society of Otolaryngology/Head and Neck Surgery
Program Chairman: Albert A. Clairmont, M.D., Atlanta

Pathology: Georgia Association of Pathologists
Program Chairman: A. Bleakley Chandler, M.D., Augusta

Atlanta Society of Pathologists
Program Chairman: Sara F. Nolting, M.D., Marietta

Plastic Surgery: Georgia Society of Plastic Surgeons
Program Chairman: W. Jefferson Pendergrast, M.D., Atlanta

* Dr. Keener, a neurosurgeon, is Chairman of MAG's Committee on Scientific Assembly.

Psychiatry: Georgia Psychiatric Association
Program Chairman: John B. Griffin, Jr., M.D., Atlanta

Surgery: Georgia Chapter, American College of Surgeons
Program Chairman: William M. McKinnon, M.D., Atlanta; Talmadge A. Bowden, Jr., M.D., Augusta

Added Feature:
Hemophilia Symposium for Providers

Program Chairmen for Hemophilia of Georgia, Inc.: Edna Phelan, M.D., Atlanta, and C. Lawrence Lutcher, M.D., Augusta.

Registration Information

Please register for the Scientific Assembly by completing the registration form inserted in the back of this *Journal,* detaching it from the hotel reservation form, and mailing it with your registration fee to the MAG headquarters office.

MAG Registration fee for Physicians (for most programs): MAG MEMBER, $50; NON-MEMBER, $75.

Surgery program: member of MAG or American College of Surgeons, $100; non-member, $125.

There is NO FEE for resident physicians, medical students, program chairmen, or speakers.

Fee for other health professionals, $20.

Hotel Reservations

If you wish hotel accommodations, please complete and detach the bottom portion of the registration form and mail it directly to the Ritz-Carlton Buckhead Hotel by October 15, 1984. Reservations will be held until 6 p.m. unless guaranteed or covered by deposit.

Highlights of the Weekend

The full program for all specialties will be printed in the October *Journal.* Here are a few highlights for some of our sessions:

Friday, November 16

Allergy (Sponsored by the Allergy and Immunology Society of Georgia)

— "Immunologic Considerations in Infectious Disease" and "Laboratory Evaluation of Allergy and Immunologic Function," Charles H. Kirkpatrick, M.D., Denver, Colo.

— "Selective IgA Deficiency: Immunologic Function of Ill Patients," Carla H. Ingold, M.D., Atlanta

— "Cold Urticaria Associated with C4 Deficiency: Case Report and Review of Literature," Chester T. Stafford, M.D., Augusta

— "IgG Subclasses and Antibody Responses in Children with Chronic Chest Symptoms," Thomas F. Smith, M.D., Atlanta

— "Terfenadine in the Treatment of Ragweed Pollinosis in Children," Tesheem K. Chaudhary, M.D., Augusta

Chest Disease (Sponsored by the Georgia Thoracic Society and Georgia Chapter, American College of Chest Physicians)

This all-day program on Friday will address difficult pulmonary infections. The morning session will feature presentations on "Opportunistic Pneumonias in the Compromised Host." In the afternoon, speakers will provide updates on Legionnaire's Disease, AIDS, atypical pneumonias, atypical mycobacteria, mycoplasma, and empyema.

Gastroenterology (Sponsored by the Georgia Gastroenterologic Society)

— "Immunoprophylaxis of Viral Hepatitis," John T. Galambos, M.D., Atlanta

— "Infectious Colitis: Mimicing Inflammatory Bowel Disease," Francis J. Tedesco, M.D., Augusta

— "Gastrointestinal Manifestations of Acquired Immune Deficiency Syndrome," Steven J. Morris, M.D., Atlanta

Otolaryngology/Head and Neck Surgery (Sponsored by the Georgia and Greater Atlanta Societies of Otolaryngology/Head and Neck Surgery)

— "The Prevention and Treatment of Infections in Cosmetic Surgery of the Head and Neck," William E. Silver, M.D., Atlanta

— "The Antibiotic and Surgical Management of Acute and Chronic Otitis Media and Mastoiditis" and "Antibiotic and Surgical Management of Acute and Chronic Sinusitis," G. Richard Holt, M.D., San Antonio, Texas

— "The Choice of Prophylactic Antibiotics in Surgery of the Head and Neck," Jonas Shulman, M.D.

— "Pediatric Aspects of Croup, Epiglottitis Retropharyngeal Abscess," Wendell Todd, M.D., Phoenix, Ariz.

Psychiatry (Sponsored by the Georgia Psychiatric Association)

On Friday afternoon, featured speaker is Alan Gelenberg, M.D., Associate Professor of Psychiatry at Harvard Medical School. Dr. Gelenberg also serves as Psychiatrist-in-Chief of the Arbor, a psychiatric hospital in Boston, and as Chief of the Special Studies Clinic, a psychopharmacology research unit under the auspices of both Massachusetts General Hospital and the Arbor.

— "Advanced Psychopharmacology: Use of Drugs in Complex Clinical Problems" will be Dr. Gelenberg's subject, which will be followed by

responses from faculty at Emory and the Medical College of Georgia.

Surgery (Sponsored by the Georgia Chapter, American College of Surgeons)

On both Friday and Saturday, the Georgia Chapter will offer the SESAP-IV Review Course. To cover the costs of faculty and the ACS protocol, a special fee is required of each registrant for this program: $100 for MAG or ACS members; $125 for non-member physicians. The Friday program will be described in the October *Journal*.

Saturday, November 17

Chest Disease (Sponsored by the Georgia Thoracic Society and Georgia Chapter, American College of Chest Physicians)

— "Physiology of Exercise: An Update and Overview," Larry Jackson, M.D., Birmingham, Ala.
— "Exercise Testing: Cardiac vs. Pulmonary Dyspnea," Barry Fowler, M.D., Charlottesville, Va.
— "Practical Aspects of Exercise in the Rehabilitation of the Pulmonary Patient," Bill Kenny, M.D., Atlanta

A panel on exercise and rehabilitation with the above faculty will follow. The program is scheduled for Saturday morning.

Emergency Medicine (Sponsored by the Georgia Chapter, American College of Emergency Physicians)

This morning program on various management procedures in the Emergency Room will offer Category I ACEP credit.

Hemophilia Symposium for Providers

Hemophilia of Georgia, Inc. will present a morning program for physicians and other providers:

— "Current Concepts in Hemophilia," Peter Levine, M.D., Worcester, Mass.
— "DDAVP: A New Treatment Approach to Hemophilia," Elna Phelan, M.D., Atlanta
— "Management of Inhibitors," C. Lawrence Lutcher, M.D., Augusta
— "Dental Care for the Hemophilia Patient," Michael Healey, D.D.S., Atlanta
— "Epidemiological and Etiological Considerations of AIDS," Bruce Evatt, M.D., Atlanta
— "Hemophilia Care in Georgia," Pamela Bertagnoll, R.N., M.N., M.P.H.

Lunch will follow this session and will include questions and answers with the faculty. Physicians attending this morning program and luncheon should contact the office of Hemophilia of Georgia, Inc., 241 West Wieuca Road, N.E., Ste. 104, Atlanta 30342. Please enclose your check for $5.00. Major funding for the luncheon is provided by ALPHA PHARMACEUTICALS.

Neurology (Sponsored by the Georgia Neurological Society)

The program, from 9:00 am to 3:00 pm, will focus on peripheral neuropathy. Featured speakers are Herbert Schaunberg, M.D., of the Albert Einstein Medical Center in New York, and Thomas R. Swift, Medical College of Georgia.

Neurosurgery (Sponsored by the Georgia Neurosurgical Society)

— "Infections," Stephen W. Schwarzmann, M.D., Atlanta
— "Intraspinal Epidural Abscesses" and "Intracranial Suppuration," Kemp Clark, M.D., Dallas, Texas
— "Complications of Shunts with Particular Reference to Infections," Mark S. O'Brien, M.D., Atlanta
— "Reconstructive Cranial Surgery: Post-infectious Processes," Larry V. Carson, M.D., Augusta.

Program continued on Sunday.

Pathology (Sponsored by the Georgia Association of Pathologists)

This morning program features James L. O'Quinn, M.D., and Mary H. O'Quinn, M.D., of Augusta speaking on infectious diseases of the skin and diagnostic immunofluorescence of the skin. See also program for Sunday.

Plastic Surgery (Sponsored by the Georgia Society of Plastic Surgeons)

In the morning, George C. Peck, M.D., Associate Clinical Professor of Plastic Surgery at the College of Physicians and Surgeons, Columbia University, will speak on rhinoplasty.

Surgery (Sponsored by the Georgia Chapter, American College of Surgeons)

The SESAP-IV Review Course is continued from Friday, with these presentations:

Anesthesia — Peggy G. Duke, M.D., Atlanta
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Immunology/Cancer — Donald H. Campbell, M.D., F.A.C.S., Marietta
Intensive Care — G. Tom Shires, Jr., M.D., F.A.C.S., Atlanta

Nutrition — J. Timothy Fulenwider, M.D., F.A.C.S., Atlanta
Pediatric Surgery — Richard R. Ricketts, M.D., F.A.C.S., Atlanta
Head and Neck — John T. Coleman, III, M.D., F.A.C.S., Atlanta
Breast — Eugene D. Davidson, M.D., F.A.C.S., Atlanta

Sunday, November 18

Neurosurgery (Sponsored by the Georgia Neurosurgical Society)

In the morning the Society will offer a socio-economic program with Dale Richardson, M.D., of Atlanta; Ellis Keener, M.D., of Gainesville, and B. J. Anderson, J.D., Associate General Counsel of the American Medical Association. Following, Joseph Barnett, M.D., of Marietta, will preside at the Georgia Neurosurgical Society's business meeting.

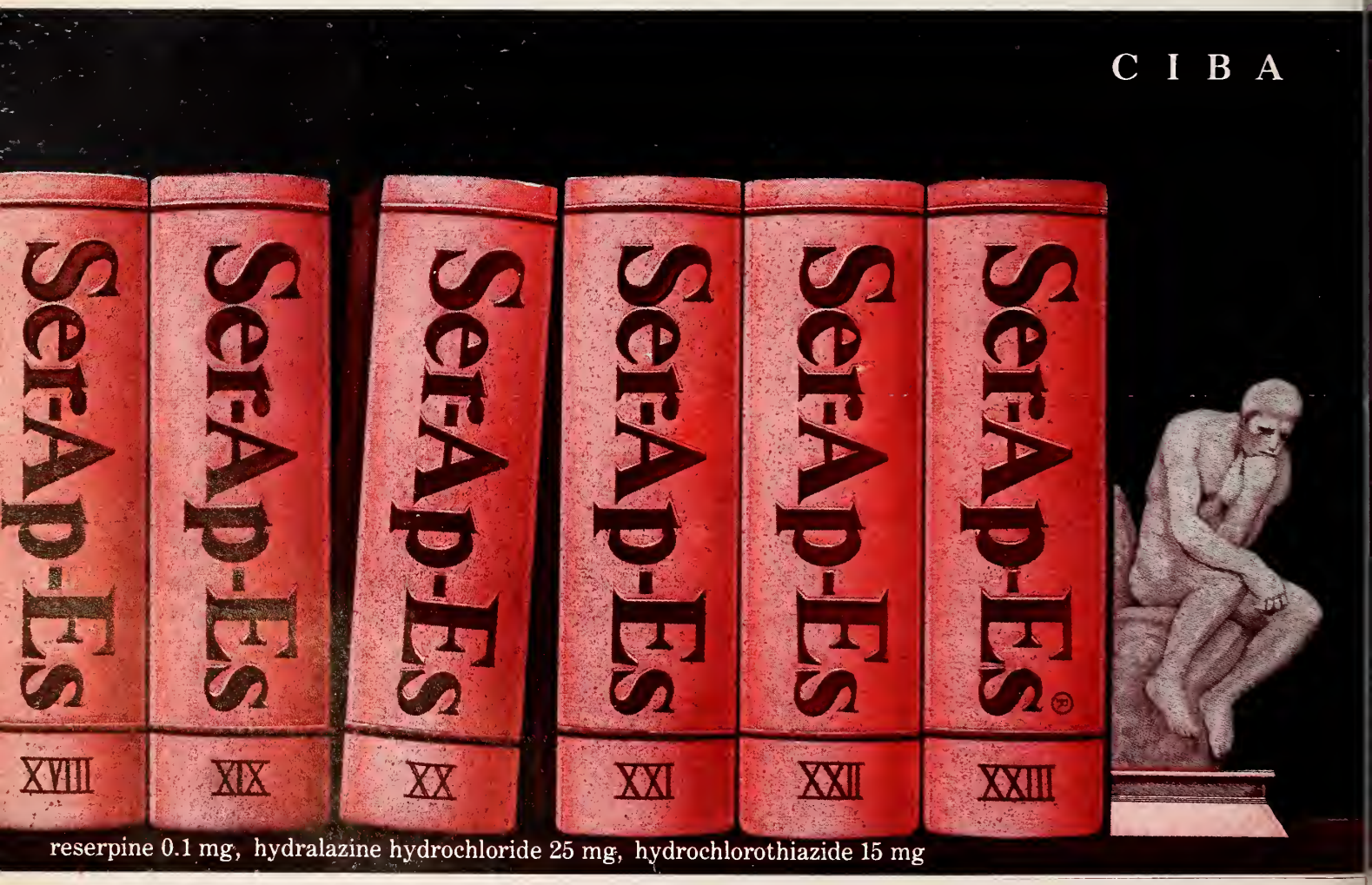
Pathology (Sponsored by the Atlanta Society of Pathologists)

The ASP Annual Slide Seminar will feature Daniel H. Connor, M.D., Chairman of the Department of Infectious and Parasitic Diseases Pathology at the Armed Forces Institute of Pathology in Washington. Dr. Connor will speak on "Pathology of Infectious and Parasitic Diseases" from 9:00 am to 2:00 pm.

Microscopic slide study sets, including clinical protocols, have been prepared for the 20 cases which Dr. Connor will present. Each set contains 33 slides, with hematoxylin and eosin as well as appropriate special stains. Limited sets are available for $60, and requests should be mailed to:

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ssisi N, Cohn A, Davidson T, et al: Diffuse otitis externa: Clinical microbiologic findings in the course of a multicenter study on a otic solution. *Ann Otol Rhinol Laryngol* 86(suppl 39, pt 3):1-16.



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14-16—*Hilton Head Island, SC:* **The Georgia Society of Anesthesiologists and the South Carolina Society of Anesthesiologists Fall Meeting.** Category 1 credit. Contact William Hammonds, Secy.-Treas., Ga. Society of Anesth., Emory Univ. Hosp., 1364 Clifton Rd., NE, Atlanta 30322. PH:404/321-0111.

16-20—*Atlanta:* **Demonstrations in Percutaneous Transluminal Angioplasty XII.** Category 1 credit. Contact Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., NE, Ste. 110, Atlanta 30322. PH:404/329-5695.

20-23—*Sea Island:* **Georgia Surgical Society Annual Meeting.** Category 1 credit. Contact William McGarity, M.D., Emory Univ. Clinic, 1365 Clifton Rd., NE, Atlanta 30322. PH:404/321-0111 x 3322.

23-26—*Sea Island:* **Georgia Urological Association Annual Meeting.** Contact Richard Estes, M.D., Secy.-Treas., 35 Collier Rd., NW, Ste. 700, Atlanta 30308. PH:404/355-0813.

28-30—*St. Simons Island:* **Georgia Gastroenterologic Society Annual Scientific Sessions.** Category 1 credit. Contact Theodore Hersh, M.D., Emory Clinic, 1365 Clifton Rd., NE, Atlanta 30322. PH:404/321-0111.

29—*Atlanta:* **Head, Neck, and Oral Cancer: Patient Management.** Cosponsored by the Ga. Div., Amer. Cancer Socy. and Emory Univ. Sch. of Dentistry. Category 1 credit. Contact Janet Bonfiglio, Dir. of Prof. Ed., Ga. Div., ACS., 1422 W. Peachtree St., NE, Atlanta 30309. PH: 404/892-0026 Ext. 41.

OCTOBER

4-6—*Atlanta:* **Endourology.** Contact Merrily Laube, Southern Found. for Edu. and Medical Research, Inc., 98 Currier St., Atlanta 30308. PH:404/688-3323.

4-6—*Hilton Head Island, SC:* **Frontiers in Nutrition** (cosponsored with Vanderbilt Univ. Sch. of Med.) AMA Category 1 and AAFP prescribed credit. Contact Div. of Cont. Ed., MCG, Augusta 30912. PH:404/828-3967.

10-11—*Atlanta:* **The Risks and Benefits of Family Planning.** Category 1 credit. Contact Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., NE, Ste. 110, Atlanta 30322. PH:404/329-5695.

15-18—*Atlanta:* **The 5th International Food Allergy Symposium,** presented by the American Coll. of Allergists. Contact Amer. Coll. of Allergists, 2141 14th St., Boulder, CO 80302. PH:308/447-8111.

15-20—*Augusta:* **Obstetrics & Gynecology.** Category 1 credit. Contact Div. of Cont. Ed., MCG, Augusta 30912. PH:404/828-3967.

18-21—*Sea Island:* **Georgia Orthopaedic Society Annual Meeting.** Category 1 credit. Contact William C. Collins, M.D., Secy.-Treas., GOS, 993 Johnson Ferry Rd., NE, Ste. 100, Atlanta 30342. PH:404/255-4582.

21-24—*Atlanta:* **Teaching Family Medicine in an Era of Competition.** Sponsored by the Family Medicine Educators in Georgia AAFP prescribed credit. Contact Georgia Academy of Family Physicians, 11 Corporate Square, Ste. 205, Atlanta 30329. PH:404/321-7445.

24-26—*Atlanta:* **Skeletal Radiology.** Category 1 credit. Contact Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., NE, Atlanta 30322. PH:404/329-5695.

24—*Columbus:* **Day of Endocrinology.** Category 1 and AAFP prescribed credit. Contact Judy Anderson, Int. Med. Found., P.O. Box 311, Columbus 31902-0311. PH:404/571-1454.

25—*Atlanta:* **Health and Fitness: The Corporate View.** Contact Barb Christopherson, Health and Fitness, P.O. Box 52406, Cedar Rapids, Iowa 52404. PH:319/365-1663.

28-31—*Helen:* **Psychiatric Institute on Group Behavior and Group Leadership.** Category 1 credit. Contact Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., NE, Ste. 110, Atlanta 30322. PH:404/329-5695.

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NOVEMBER

5-10—*Atlanta:* **American Society of Cytology.** Contact ASC, 130 S. 9th St., Ste. 810, Philadelphia, PA 19107. PH:215/922-3880.

11-16—*Atlanta:* **American Academy of Ophthalmology.** Contact AAO, P.O. Box 7424, 1833 Filmore St., San Francisco, CA 94120. PH:415/921-4700.

15-18—*Atlanta:* **Georgia Academy of Family Physicians' Annual Meeting.** Category 1 and AAFP prescribed credit. Contact Camille Day, Exec. Vice-Pres., GAFP, 11 Corporate Square, Ste. 205, Atlanta 30329. PH:404/321-7445.

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28-Dec. 2—*Atlanta:* **Ninth Southeastern Conference on Alcohol and Drug Abuse.** Contact Barbara Turner, Charter Med. Corp., Addictive Disease Div., 5780 Peachtree-Dunwoody Rd., N.E., #170, Atlanta 30342.

DECEMBER

1-2—*Atlanta:* **Regional Anesthesia: Surgery, Obstetrics, and Pain.** Category 1 credit. Contact Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., NE, Ste. 110, Atlanta 30322. PH:404/329-5695.

3-7—*Atlanta:* **MKSAP VI Review Course.** Category 1 credit. Contact Registrar, Amer. Coll. of Phy., 4200 Pine St., Philadelphia, PA 19104. PH:800/523-1546.

6-9—*Atlanta:* **From Head to Toes: A Practical Approach to Orthopaedics for the Primary Care Physician.** Category 1 credit. Contact Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., NE, Ste. 110, Atlanta 30322. PH:404/329-5695.

Probably no other general category of patients causes as much confusion, frustration, and exasperation for the physician as this one.

Differential Diagnosis and Management of the Chronically Somatizing Patient

ALAN STOUDEMIRE, M.D., *Atlanta**

PATIENTS WITH "multiple somatic complaints" form a significant component of the practices of most family and general medical physicians.[1] Probably no other general category of patients causes as much confusion, frustration, and exasperation for the physician as this group of patients who often present with a seemingly endless litany of complaints. The matter is complicated further by the fact that many of these patients do indeed suffer from various degrees of organic diseases but whose complaints are often magnified or intermixed with symptoms that seem to be of a more functional nature.

An approach will be offered in this review for the evaluation and management of this spectrum of patients based on diagnostic categories contained in the new Diagnostic and Statistical Manual of the American Psychiatric Association (DSM-III)[2] (Table 1). Since the presence of somatic symptoms is so prevalent in psychiatric disorders, it can be seen from the list of diagnostic possibilities that patients who present with multiple somatic complaints comprise a *heterogenous* patient population. This discussion will briefly review these diagnostic possibilities, paying particular attention to somatic complaints that are often representative of "masked" depression and anxiety. Special emphasis will also be placed on the clinical management of the most difficult of somatizing patients, the hypochondriac.

* Dr. Stoudemire is Assistant Professor of Psychiatry, Emory University School of Medicine. Send reprint requests to him at the Emory University Clinic, Section of Psychiatry, 1365 Clifton Rd., NE, Atlanta, GA 30322.

Somatoform Disorders

Somatoform disorders are characterized by the presence of physical symptoms for which there are no demonstrable organic findings for the patient's complaint. In the somatoform disorders (hypochondriasis, somatization disorder, psychogenic pain disorder, and conversion disorder), the functional symptom may result from unconscious conflicts or other psychologic factors that are obscure to both the doctor and patient. As such, the underlying psychologic reasons for these patients' complaints are rarely immediately apparent.

Somatization Disorders

The first diagnosis under the somatoform disorders, somatization disorder, is characterized by a history of physical symptoms that usually begin before age 30. As such, these patients have apparently made illness a "way of life." These patients tend to be polysymptomatic with complaints that are referable to almost every organ system — and may shift from system to system within the course of even a brief interview. They tend to have "sickly personalities" with various types of illnesses that date back to childhood. Their medical history may be replete with many exploratory surgeries whose results are negative. These patients may also "doctor shop." Their symptoms, as noted above, usually involve multiple organ systems including cardiorespiratory (sighing, shortness of breath, chest tightness and pain, palpitations), neurologic (dizziness, headache, blurred vision), vague gastrointestinal pain complaints, and amorphous symptoms related to the

genitourinary tract. This disorder, which occurs predominately in women, has formerly been referred to as hysteria or Briquet's Syndrome. Many of the patients present with concurrent anxiety and depression.

Hypochondriasis

In contrast, the hypochondriac also presents with physical complaints but is convinced that an organic illness is present. These patients are usually anxiously obsessed that a somatic complaint, or a series of complaints, represent fearful life-threatening illness. What tends to be diagnostic for the hypochondriac, however, is that these patients cannot be reassured either by the physician or negative diagnostic tests. Such patients tend to cling to their symptoms as a person who has been safely rescued from drowning continues to cling to their life raft — they cannot be convinced that they are indeed "safe."

Hypochondriacal patients tend to present in two stereotypical personality styles: dependent and hostile. The more dependent hypochondriac may persist in their complaints and worries but usually does not harass the physician — they just tend to reappear with recurrent symptoms. Hostile hypochondriacs, however, may be provocative, litiginous, and even threatening. They may demean the physician as uncaring or incompetent — thus often engendering the wrath and frustration of exasperated doctors who become "burned out" in their efforts to reassure their patients. It is the hostile hypochondriac who tends to cause the most problems in the medical care system.

One theory suggests that the somatizing patient or hypochondriac is seeking attention, comfort, reassurance, and love through the expression of physical complaints. . . .

No totally satisfactory explanation has ever been offered to completely explain the causes of either somatization disorder or hypochondriasis. Part of the difficulty in understanding these patients is the fact that they are often extremely threatened by a psychologic approach to their symptoms and thus rarely follow through with psychiatric referral. They are thus a difficult population to treat or study systematically in research settings.

There are, however, four broad approaches to understanding the psychology of hypochondriacal and somatizing patients.[3] Classic psychoanalytic views understood these patients as developmentally "fixated" at infantile levels of psychosexual development. They thus tend to channel aggressive and sexual drives and conflicts through somatic channels rather than resolving them at verbal, conscious levels. Other psychodynamic theorists believe hypochondriasis serves as a defense against guilt or low self-esteem; it is more psychologically tolerable to the individual to feel that something is wrong with their body than to acknowledge there is something wrong with the "self." Painful somatic symptoms may serve as an expiation or atonement for guilt over past "wrongs" or as punishment for forbidden, unconscious angry impulses. Other writers have argued for a "cognitive" abnormality in these patients in that they over-amplify, misinterpret, or over-attend to bodily signals or symptoms that other individuals dismiss or ignore.[3]

These disorders have also been interpreted along behaviorist and social learning models. In this approach, the somatizing patient or hypochondriac is seeking attention, comfort, reassurance, and love through the expression of physical complaints — a pattern that may have been learned in childhood. Thus, hypochondriasis and somatization disorder may be a product of defective or inadequate social learning skills. Since the individual cannot verbally ask for or seek in an appropriate interpersonal manner the care and attention they seek — they need an excuse, or a "ticket," to get these needed emotional supplies from physicians or other family members.

None of these theories is entirely complete in themselves and to some extent may operate in any given patient simultaneously. Despite their theoretical limitations, they have important treatment implications as will be noted later in this discussion.

Conversion Disorders and Psychogenic Pain Disorder

Two other diagnoses under the somatoform disorders should be considered in the context of chronically somatizing patients — these include conversion disorder and psychogenic pain disorder. Conversion disorders are characterized by a loss or alteration of physical functioning (i.e., paralysis or blindness) which is not consistent with known neurophysiologic pathways. A temporal relationship may exist between the onset of the disorder and a life crisis. These symptoms may arise quickly, abate, and then recur if another stress arises. Formation of the symptoms may enable the patient to avoid emotionally dealing with an unpleasant event and thus keep both the conflict and their emotional response to it unconscious. The symptom may also serve to enable the patient to derive attention and support from their environment which would not be forthcoming otherwise; i.e., secondary gain. A caveat to bear in mind before making this diagnosis, however: approximately 15-30% of patients who receive the diagnosis of "hysterical" conversion disorder turn out to have occult disease to account for their symptoms.[4]

Psychogenic pain disorder is similar to conversion disorder in that there usually exists inconsistency of the pain complaints with known pain pathways and a lack of demonstrable organic findings. One should consider whether the pain complaint enables the patient to avoid some unpleasant task or other type of secondary gain that may be derived from the symptom. Psychogenic pain, however, tends to be more chronic in nature than the episodic, fluctuating nature of conversion disorders. Since conversion disorders and psychogenic pain disorders usually require more formalized, intensive psychiatric treatment and evaluation than is feasible for primary care physicians to provide, the management of these conditions will not be specifically considered further.

Although conversion disorders have traditionally been labeled as "hysterical," this disorder occurs in many personality types. Histrionic or hysterical personalities, however, tend to be more prone to this pattern of symptom formation. Much has also been written about the peculiar lack of concern about their symptoms that such patients often exhibit (la belle indifference) but this is not a consistent finding in conversion disorders.[4]

Differential Diagnosis of the Somatizing Patient

The cardinal rule in the management of these disorders is to rule out underlying organic illness before attributing symptom formation to psychiatric causes. The most deceiving clinical situation, however, arises when the previously diagnosed hypochondriac develops an organic illness — such as angina or an occult carcinoma. Having been labeled hypochondriacal, the symptoms may be ignored until they reach crisis proportions. Hypochondriacs are not immortal!!

After eliminating a possible occult medical problem as a cause for the somatizing patient's complaints, several psychiatric diagnostic possibilities should be considered in addition to the somatoform disorders. These include "masked" depression symptoms, grief reactions, stress related psychophysiologic symptoms, factitious disorders and malingering. Each of these diagnostic possibilities will be considered below.

Masked Depressions

Most patients with depression present with somatic symptoms. These may include sleep disturbance, psychomotor retardation, decreased sex drive, lassitude, appetite loss, gastrointestinal distress, headaches, backaches, weight loss, and generalized musculoskeletal pain. If the patient can also verbalize a dysphoric or depressed mood associated with a loss of interest in life, crying, low self esteem, guilt — even suicidal thoughts — the diagnosis of depression is readily made. Some patients, however, are psychologically and intellectually unsophisticated and may never be able to identify or connect their somatic complaints with depression.[5] Such patients therefore stay in fixed somatic manner in expressing their underlying depressed mood. Many of these patients will nevertheless respond to pharmacologic treatment with antidepressants despite their lack of insight. Especially in the elderly, the onset of agitation associated with hypochondriacal symptoms is a common presentation for depression. Most depressions are also associated with anxiety symptoms with many autonomic psychophysiologic sequelae, such as palpitations, nausea, vomiting, diarrhea, nervousness, restlessness, and insomnia.

Table 1 — Differential Diagnosis of Chronically Somatic Patients

Occult Organic Disease
Somatoform Disorders
Somatization disorders
Hypochondriasis
Conversion disorders
Psychogenic pain disorders
Major Depression (includes "masked" depression)
Grief Reactions
Psychophysiologic Reactions to Stress
(Psychological factors affecting physical condition)
Factitious disorder (with psychological or physical symptoms)
Malingering

Grief Reactions

Grief is not only a psychologic state of sadness but also has somatic expressions as well. Somatic symptoms may include throat tightness, dysphagia, and chest pain especially in the early stages of a grief reaction. Grief at times may resemble or merge into a major depression with the many vegetative symptoms noted above. Somatic symptoms may be predominant, with the bereaved individual focusing on their body rather than facing the underlying sadness they may wish to avoid. Grief reactions which are prolonged (past 12 months) or merge into major depression require psychiatric attention.[6]

Transient, Stress-related Psychophysiologic Symptoms

Physical symptoms that are caused by reactions to stress or anxiety must be considered in chronically somatizing patients. In contrast to conversion disorders and somatization disorders, the patient's symptoms can be understood by known physiologic pathways and mechanisms (muscle contraction or vascular spasm in headache syndromes, excess gastric secretion in gastric pain, autonomic discharge in diarrhea, or palpitations). There is rarely secondary gain involved, and patients tend to acknowledge the relationship between their physical symptoms and stress. These patients are not obsessively preoccu-

pied with fear of disease and tend to welcome symptom relief. Symptoms tend to abate as social or occupational stressors abate.

Malingering and Factitious Disorders

In malingering, symptoms are created by the patient, are under voluntary control and are motivated to achieve an identifiable goal; e.g., disability compensation. In factitious disorders, symptoms are also under voluntary control and are fabricated by the patient, but the only identifiable goal is to achieve or maintain the role of a patient.[7] Examples include factitious fevers (by surreptitiously rubbing thermometers or self-injecting feces), and feigning psychosis to gain psychiatric hospitalization. The classic pattern of factitious disorder is known as Munchausen's Syndrome. In the somatoform disorders (conversion disorders, psychogenic pain, somatization disorder, and hypochondriasis), symptom formation is involuntary; symptoms in factitious disorders and malingering are under voluntary control.

Management of Somatization Disorder and Hypochondriasis

Optimal treatment in medicine follows from precision in diagnosis; the same dictum holds for psychiatric disorders. Since patients with multiple somatic complaints form a heterogenous population, chances of successful management will be heightened by appropriate diagnosis. Even patients who are chronically hypochondriacal may exhibit symptom reduction and achieve high levels of psychosocial functioning if managed according to the treatment strategies outlined below.[8-11]

The cardinal rule in the management of these (somatic) disorders is to rule out underlying organic illness before attributing symptom formation to psychiatric causes.

After occult organic illness and depression are ruled out, a treatment plan to *manage* (rather than cure) the hypochondriacal/polysymptomatic somatizing patient should be effected. A cardinal principal to be emphasized, however, is that the last thing these patients may want is a "cure." As noted earlier, these patients are suffering from developmental fixations that lead them to operate in socially primitive patterns; they tend to have poorly developed cognitive, verbal, and interpersonal skills. Because of underlying personality deficits and dependency needs, they often need attachment to an ongoing relationship with an authority figure to give the reassurance, support, attention, and emotional nurturance they cannot elicit in a mature adult relationship. As such, the physician serves as a parent figure. The physical symptoms serve as a "somatic ticket" of entrance to this relationship with the doctor and therefore legitimizes their seeking help and medical attention. To "cure" the hypochondriacal/somatizing patient would be a threat to this needed relationship.

Management of these patients in the primary care setting involves seeing the patient in the context of an ongoing, continuing relationship which is not dependent on symptom formation by the patient as an excuse for office visits.

Most of these patients suffer from some form of emotional deprivation in childhood. They thus seek to re-enact with their physician patterns of their unsatisfying and emotionally frustrating relationships they had with their parents. If residual anger and hostility remain latent in the patient's unconscious towards the disappointing and depriving parent, much of this anger may then be displaced on the physician whom the patient anticipates will neglect and disappoint them as did their parent. The patient's communication of emotional distress, however, is delivered through somatic patterns. There will be little or no conscious connections made by the patient between their experience of somatic symptoms and their childhood experiences.

These considerations are important for a number of reasons. They explain the somatizing patient's dependency on the physician and their resistance to reassurance, particularly if reassurance implies they no longer need to see the doctor. The dependency exhibited by these patients, however, is often intolerable for many physicians to bear. If the hypochondriacal patient is hostile and provocative, contact with a physician is usually confrontative and terminates angrily early in the encounter.

Management of these patients in the primary care setting involves seeing the patient in the context of an ongoing, continuing relationship which is *not* dependent on symptom formation by the patient as an excuse for office visits. If the patient is seen regularly with fixed intervals for brief periods of time, there will be less likelihood of exacerbation of symptoms leading to night calls, emergency room visits, and further doctor shopping. The physician should transmit to such patients that he is concerned about their problems, that they need attention and follow-up, but that at the present time no further diagnostic testing is necessary. During the course of office visits, the focus should gradually and subtly be shifted away (indirectly) from a discussion of physical problems and complaints to an exploration of other aspects of the patient's life, such as family

or social activities and interests. In this manner, the patient's anxiety about being discharged is alleviated, there is less need to focus on somatic symptoms to gain the doctor's attention, and the patient may learn to use the physician's time to discuss areas in their life which may be a source of anxiety and depression. Many patients with hypochondriasis and somatization are prone to supervening depressions and anxiety disorders which may at times need formal psychiatric attention.

It is not realistic that all physicians will have the time, patience, or general inclination to treat hypochondriacal/chronically somatizing patients. Each physician should decide when evaluating these types of patients whether they have the time, interest, and patience to take on responsibility for individuals who are at times demanding and draining. Despite the demands of such patients, limits can be placed on what the physician can realistically provide, and some general understanding of this should be transmitted to the patient. While the patient can be reassured that they will be seen on a regular basis whether they are "better or worse," the time and frequency interval of each office visit should be set, as well as on what conditions nonemergent telephone calls will be taken. A fee structure should be set both for office visits and telephone calls as well as the ramifications for non-payment. The medications that the doctor will provide should be clearly understood to prevent manipulations for tranquilizers or narcotics. Rather than being turned away by such a firm, structured approach, many patients will view this as a sign of genuine interest and concern on the physician's part and thus symptom formation will usually diminish.

The therapeutic gains to be made with these patients is usually minimal, although centralizing and stabilizing their care will diminish their drain on the medical system. Some patients, however, given the relative security of the doctor-patient relationship, are capable of some degree of personal growth. Helping this group of patients is a test of patience for physicians and one of the most difficult challenges in the psychologic aspects of patient care.

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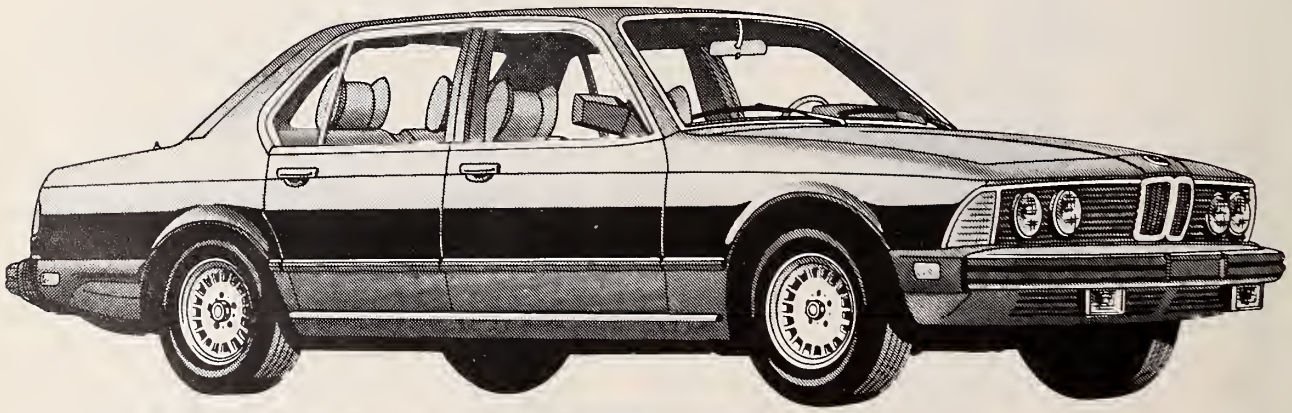
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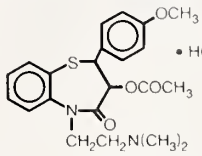
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DESCRIPTION

CARDIZEM® (diltiazem hydrochloride) is a calcium ion influx inhibitor (slow channel blocker or calcium antagonist). Chemically, diltiazem hydrochloride is 1,5-Benzothiazepin-4(5H)one,3-(acetyloxy) -5-[2-(dimethylamino)ethyl]-2,3-dihydro-2-(4-methoxyphenyl)-, monohydrochloride,(+) -cis-. The chemical structure is:



Diltiazem hydrochloride is a white to off-white crystalline powder with a bitter taste. It is soluble in water, methanol, and chloroform. It has a molecular weight of 450.98. Each tablet of CARDIZEM contains either 30 mg or 60 mg diltiazem hydrochloride for oral administration.

CLINICAL PHARMACOLOGY

The therapeutic benefits achieved with CARDIZEM are believed to be related to its ability to inhibit the influx of calcium ions during membrane depolarization of cardiac and vascular smooth muscle.

Mechanisms of Action. Although precise mechanisms of its antianginal actions are still being delineated, CARDIZEM is believed to act in the following ways:

1. Angina Due to Coronary Artery Spasm: CARDIZEM has been shown to be a potent dilator of coronary arteries both epicardial and subendocardial. Spontaneous and ergonovine-induced coronary artery spasm are inhibited by CARDIZEM.
2. Exertional Angina: CARDIZEM has been shown to produce increases in exercise tolerance, probably due to its ability to reduce myocardial oxygen demand. This is accomplished via reductions in heart rate and systemic blood pressure at submaximal and maximal exercise work loads.

In animal models, diltiazem interferes with the slow inward (depolarizing) current in excitable tissue. It causes excitation-contraction uncoupling in various myocardial tissues without changes in the configuration of the action potential. Diltiazem produces relaxation of coronary vascular smooth muscle and dilation of both large and small coronary arteries at drug levels which cause little or no negative inotropic effect. The resultant increases in coronary blood flow (epicardial and subendocardial) occur in ischemic and nonischemic models and are accompanied by dose-dependent decreases in systemic blood pressure and decreases in peripheral resistance.

Hemodynamic and Electrophysiologic Effects. Like other calcium antagonists, diltiazem decreases sinoatrial and atrioventricular conduction in isolated tissues and has a negative inotropic effect in isolated preparations. In the intact animal, prolongation of the AH interval can be seen at higher doses.

In man, diltiazem prevents spontaneous and ergonovine-provoked coronary artery spasm. It causes a decrease in peripheral vascular resistance and a modest fall in blood pressure and, in exercise tolerance studies in patients with ischemic heart disease, reduces the heart rate-blood pressure product for any given work load. Studies to date, primarily in patients with good ventricular function, have not revealed evidence of a negative inotropic effect; cardiac output, ejection fraction, and left ventricular end diastolic pressure have not been affected. There are as yet few data on the interaction of diltiazem and beta-blockers. Resting heart rate is usually unchanged or slightly reduced by diltiazem.

Intravenous diltiazem in doses of 20 mg prolongs AH conduction time and AV node functional and effective refractory periods approximately 20%. In a study involving single oral doses of 300 mg of CARDIZEM in six normal volunteers, the average maximum PR prolongation was 14% with no instances of greater than first-degree AV block. Diltiazem-associated prolongation of the AH interval is not more pronounced in patients with first-degree heart block. In patients with sick sinus syndrome, diltiazem significantly prolongs sinus cycle length (up to 50% in some cases).

Chronic oral administration of CARDIZEM in doses of up to 240 mg/day has resulted in small increases in PR interval, but has not usually produced abnormal prolongation. There were, however, three instances of second-degree AV block and one instance of third-degree AV block in a group of 959 chronically treated patients.

Pharmacokinetics and Metabolism. Diltiazem is absorbed from the tablet formulation to about 80% of a reference capsule and is subject to an extensive first-pass effect, giving an absolute bioavailability (compared to intravenous dosing) of about 40%. CARDIZEM undergoes extensive hepatic metabolism in which 2% to 4% of the unchanged drug appears in the urine. In vitro binding studies show CARDIZEM is 70% to 80% bound to plasma proteins. Competitive ligand binding studies have also shown CARDIZEM binding is not altered by therapeutic concentrations of digoxin, hydrochlorothiazide, phenylbutazone, propranolol, salicylic acid, or warfarin. Single oral doses of 30 to 120 mg of CARDIZEM result in detectable plasma levels within 30 to 60 minutes and peak plasma levels two to three hours after drug administration. The plasma elimination half-life following single or multiple drug administration is approximately 3.5 hours. Desacetyl diltiazem is also present in the plasma at levels of 10% to 20% of the parent drug and is 25% to 50% as potent a coronary vasodilator as diltiazem. Therapeutic blood levels of CARDIZEM appear to be in the range of 50 to 200 ng/ml. There is a departure from dose-linearity when single doses above 60 mg are given; a 120-mg dose gave blood levels three times that of the 60-mg dose. There is no information about the effect of renal or hepatic impairment on excretion or metabolism of diltiazem.

INDICATIONS AND USAGE

1. **Angina Pectoris Due to Coronary Artery Spasm.** CARDIZEM is indicated in the treatment of angina pectoris due to coronary artery spasm. CARDIZEM has been shown effective in the treatment of spontaneous coronary artery spasm presenting as Prinzmetal's variant angina (resting angina with ST-segment elevation occurring during attacks).
2. **Chronic Stable Angina (Classic Effort-Associated Angina).** CARDIZEM is indicated in the management of chronic stable angina. CARDIZEM has been effective in controlled trials in reducing angina frequency and increasing exercise tolerance.

There are no controlled studies of the effectiveness of the concomitant use of diltiazem and beta-blockers or of the safety of this combination in patients with impaired ventricular function or conduction abnormalities.

CONTRAINDICATIONS

CARDIZEM is contraindicated in (1) patients with sick sinus syndrome except in the presence of a functioning ventricular pacemaker, (2) patients with second- or third-degree AV block except in the presence of a functioning ventricular pacemaker, and (3) patients with hypotension (less than 90 mm Hg systolic).

WARNINGS

1. **Cardiac Conduction.** CARDIZEM prolongs AV node refractory periods without significantly prolonging sinus node recovery time, except in patients with sick sinus syndrome. This effect may rarely result in abnormally slow heart rates (particularly in patients with sick sinus syndrome) or second- or third-degree AV block (six of 1243 patients for 0.48%). Concomitant use of diltiazem with beta-blockers or digitalis may result in additive effects on cardiac conduction. A patient with Prinzmetal's angina developed periods of asystole (2 to 5 seconds) after a single dose of 60 mg of diltiazem.
2. **Congestive Heart Failure.** Although diltiazem has a negative inotropic effect in isolated animal tissue preparations, hemodynamic studies in humans with normal ventricular function have not shown a reduction in cardiac index nor consistent negative effects on contractility (dp/dt). Experience with the use of CARDIZEM alone or in combination with beta-blockers in patients with impaired ventricular function is very limited. Caution should be exercised when using the drug in such patients.
3. **Hypotension.** Decreases in blood pressure associated with CARDIZEM therapy may occasionally result in symptomatic hypotension.
4. **Acute Hepatic Injury.** In rare instances, patients receiving CARDIZEM have exhibited reversible acute hepatic injury as evidenced by moderate to extreme elevations of liver enzymes. (See PRECAUTIONS and ADVERSE REACTIONS.)

PRECAUTIONS

General. CARDIZEM (diltiazem hydrochloride) is extensively metabolized by the liver and excreted by the kidneys and in bile. As with any new drug given over prolonged periods, laboratory parameters should be monitored at regular intervals. The drug should be used with caution in patients with impaired renal or hepatic function. In subacute and chronic dog and rat studies designed to produce toxicity, high doses of diltiazem were associated with hepatic damage. In special subacute hepatic studies, oral doses of 125 mg/kg and higher in rats were associated with histological changes in the liver which were reversible when the drug was discontinued. In dogs, doses of 20 mg/kg were also associated with hepatic changes; however, these changes were reversible with continued dosing.

Drug Interaction. Pharmacologic studies indicate that there may be additive effects in prolonging AV conduction when using beta-blockers or digitalis concomitantly with CARDIZEM. (See WARNINGS).

Controlled and uncontrolled domestic studies suggest that concomitant use of CARDIZEM and beta-blockers or digitalis is usually well tolerated. Available data are not sufficient, however, to predict the effects of concomitant treatment, particularly in patients with left ventricular dysfunction or cardiac conduction abnormalities. In healthy volunteers, diltiazem has been shown to increase serum digoxin levels up to 20%.

Carcinogenesis, Mutagenesis, Impairment of Fertility. A 24-month study in rats and a 21-month study in mice showed no evidence of carcinogenicity. There was also no mutagenic response in in vitro bacterial tests. No intrinsic effect on fertility was observed in rats.

Pregnancy. Category C. Reproduction studies have been conducted in mice, rats, and rabbits. Administration of doses ranging from five to ten times greater (on a mg/kg basis) than the daily recommended therapeutic dose has resulted in embryo and fetal lethality. These doses, in some studies, have been reported to cause skeletal abnormalities. In the perinatal/postnatal studies, there was some reduction in early individual pup weights and survival rates. There was an increased incidence of stillbirths at doses of 20 times the human dose or greater.

There are no well-controlled studies in pregnant women; therefore, use CARDIZEM in pregnant women only if the potential benefit justifies the potential risk to the fetus.

Nursing Mothers. It is not known whether this drug is excreted in human milk. Because many drugs are excreted in human milk, exercise caution when CARDIZEM is administered to a nursing woman if the drug's benefits are thought to outweigh its potential risks in this situation.

Pediatric Use. Safety and effectiveness in children have not been established.

ADVERSE REACTIONS

Serious adverse reactions have been rare in studies carried out to date, but it should be recognized that patients with impaired ventricular function and cardiac conduction abnormalities have usually been excluded.

In domestic placebo-controlled trials, the incidence of adverse reactions reported during CARDIZEM therapy was not greater than that reported during placebo therapy.

The following represent occurrences observed in clinical studies which can be at least reasonably associated with the pharmacology of calcium influx inhibition. In many cases, the relationship to CARDIZEM has not been established. The most common occurrences, as well as their frequency of presentation, are: edema (2.4%), headache (2.1%), nausea (1.9%), dizziness (1.5%), rash (1.3%), asthenia (1.2%), AV block (1.1%). In addition, the following events were reported infrequently (less than 1%) with the order of presentation corresponding to the relative frequency of occurrence.

Cardiovascular:	Flushing, arrhythmia, hypotension, bradycardia, palpitations, congestive heart failure, syncope.
Nervous System:	Paresthesia, nervousness, somnolence, tremor, insomnia, hallucinations, and amnesia.
Gastrointestinal:	Constipation, dyspepsia, diarrhea, vomiting, mild elevations of alkaline phosphatase, SGOT, SGPT, and LDH.
Dermatologic:	Pruritus, petechiae, urticaria, photosensitivity.
Other:	Polyuria, nocturia.

The following additional experiences have been noted:

A patient with Prinzmetal's angina experiencing episodes of vasospastic angina developed periods of transient asymptomatic asystole approximately five hours after receiving a single 60-mg dose of CARDIZEM.

The following postmarketing events have been reported infrequently in patients receiving CARDIZEM: erythema multiforme; leukopenia; and extreme elevations of alkaline phosphatase, SGOT, SGPT, LDH, and CPK. However, a definitive cause and effect between these events and CARDIZEM therapy is yet to be established.

OVERDOSAGE OR EXAGGERATED RESPONSE

Overdosage experience with oral diltiazem has been limited. Single oral doses of 300 mg of CARDIZEM have been well tolerated by healthy volunteers. In the event of overdosage or exaggerated response, appropriate supportive measures should be employed in addition to gastric lavage. The following measures may be considered:

Bradycardia	Administer atropine (0.60 to 1.0 mg). If there is no response to vagal blockade, administer isoproterenol cautiously.
High-Degree AV Block	Treat as for bradycardia above. Fixed high-degree AV block should be treated with cardiac pacing.
Cardiac Failure	Administer inotropic agents (isoproterenol, dopamine, or dobutamine) and diuretics.
Hypotension	Vasopressors (eg, dopamine or levarterenol bitartrate).

Actual treatment and dosage should depend on the severity of the clinical situation and the judgment and experience of the treating physician.

The oral/LD_{50}'s in mice and rats range from 415 to 740 mg/kg and from 560 to 810 mg/kg, respectively. The intravenous LD_{50}'s in these species were 60 and 38 mg/kg, respectively. The oral LD_{50} in dogs is considered to be in excess of 50 mg/kg, while lethality was seen in monkeys at 360 mg/kg. The toxic dose in man is not known, but blood levels in excess of 800 ng/ml have not been associated with toxicity.

DOSAGE AND ADMINISTRATION

Exertional Angina Pectoris Due to Atherosclerotic Coronary Artery Disease or Angina Pectoris at Rest Due to Coronary Artery Spasm. Dosage must be adjusted to each patient's needs. Starting with 30 mg four times daily, before meals and at bedtime, dosage should be increased gradually (given in divided doses three or four times daily) at one- to two-day intervals until optimum response is obtained. Although individual patients may respond to any dosage level, the average optimum dosage range appears to be 180 to 240 mg/day. There are no available data concerning dosage requirements in patients with impaired renal or hepatic function. If the drug must be used in such patients, titration should be carried out with particular caution.

Concomitant Use With Other Antianginal Agents:

1. **Sublingual NTG** may be taken as required to abort acute anginal attacks during CARDIZEM therapy.
2. **Prophylactic Nitrate Therapy**—CARDIZEM may be safely coadministered with short- and long-acting nitrates, but there have been no controlled studies to evaluate the antianginal effectiveness of this combination.
3. **Beta-blockers.** (See WARNINGS and PRECAUTIONS.)

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Cardizem 30-mg tablets are supplied in bottles of 100 (NDC 0088-1771-47) and in Unit Dose Identification Paks of 100 (NDC 0088-1771-49). Each green tablet is engraved with MARION on one side and 1771 engraved on the other. CARDIZEM 60-mg scored tablets are supplied in bottles of 100 (NDC 0088-1772-47) and in Unit Dose Identification Paks of 100 (NDC 0088-1772-49). Each yellow tablet is engraved with MARION on one side and 1772 on the other.

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Although systemic corticosteroids have been successfully used in the treatment of this disease, this case suggests that more aggressive therapy may occasionally be required.

Persistent Pleural Effusion Complicating Sarcoidosis

JOHN A. HUDSON, M.D., TERRY KELLEY, M.D., *and* K. DEAN BURKE, M.D., *Macon**

Abstract

Pleural effusions rarely complicate sarcoidosis. We expect this complication to respond to systemic corticosteroids. The effusion in the case described in this article recurred in spite of high dose corticosteroid therapy. The patient required intrapleural sclerosing for lasting benefit.

Introduction

Sarcoidosis is a multisystem disease of unknown etiology characterized by non-caseating granulomas. Pleural manifestations are uncommon and generally respond to systemic corticosteroids.[1, 2, 3] We present a case of sarcoidosis complicated by pleural effusions recurring in spite of corticosteroid therapy. Instillation of a sclerosing agent into the pleural space was required for resolution.

Case Report

A 36-year-old black woman consulted her physician in December, 1980, because of right-sided chest pain, night sweats, and episodic dyspnea. She was seen periodically thereafter for persistence of these symptoms. Palpable supraclavicular lymph nodes led to her hospitalization in March, 1981. Chest x-ray revealed bilateral hilar adenopathy. Excision biopsy of scalene nodes was performed, and histologic appearance was consistent with non-caseating granuloma. Lymph node smears and cultures were negative for acid-fast bacilli. She was placed on oral prednisone therapy. Dosage was varied according to her symptoms of cough, dyspnea, and arthralgias.

She was first admitted to the medical service of the Medical Center of Central Georgia in October, 1981. Investigation of a persistent cough led to the discovery of a right pleural effusion (Figure 1). Her dose of prednisone had been increased to 80 mgm per day by the time she was hospitalized. Thoracentesis yielded 1.5 liters of serosanguineous fluid. Laboratory examination of the fluid demonstrated 700 white blood cells per cm^3, all of which were lymphocytes; total protein — 4950 mgm/dl; glucose 91 mgm/dl; and specific gravity of 1.030. Cultures and smears for bacteria and for acid-fast bacilli were negative. No malignant cells were seen on cytologic examination. Serum angiotensin converting enzyme level was 51 IU/L with a normal range of 10-30. Arterial blood gases demonstrated hypoxemia and hypocapnia before thoracentesis. Mild hypoxemia with a normal pCO_2 persisted after the procedure. The effusion reaccumulated in spite of high dose prednisone therapy. Thoracentesis was repeated with pleural biopsy. The biopsy confirmed the presence of non-caseating granulomata. Acid-fast and silver stains of the biopsy material were negative. Improvement was sustained, and the patient was discharged after 7 days of hospitalization taking 80 mgm of prednisone daily.

The patient was re-admitted to the medical service in January, 1982, when her symptoms and the pleural effusion recurred. Steroid therapy had been con-

* Drs. Hudson, Kelley, and Burke are with the Medical Center of Central Georgia in Macon. Send reprint requests to Dr. Hudson, Mercer University School of Medicine, 1550 College Ave., Macon, GA 31201.

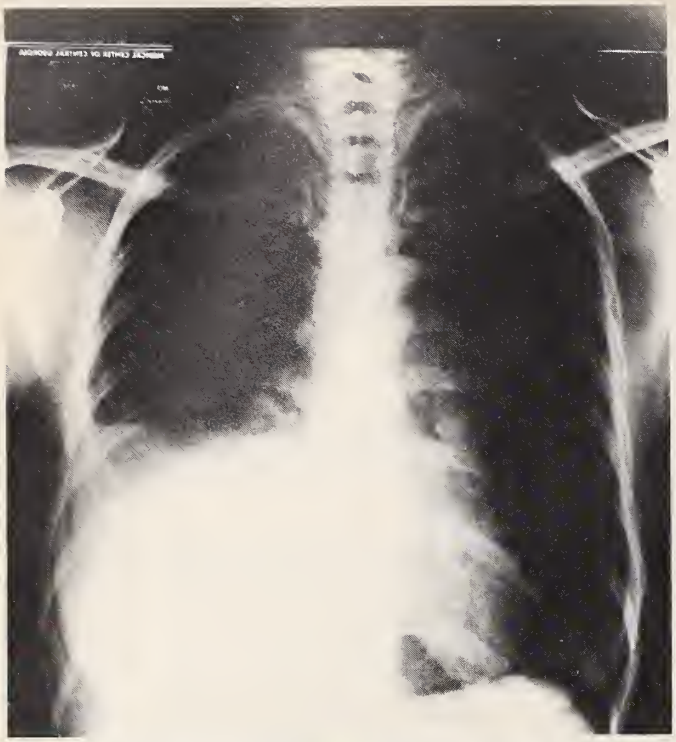


Figure 1 — Chest x-ray showing pleural effusion at the time of the patient's last hospitalization.

tinuous and verified by frequent outpatient visits. Tube thoracostomy yielded one liter of fluid. Tube drainage was continued until no further fluid could be removed. Tetracycline 500 mgm in 100 cc of normal saline was instilled as a sclerosing agent. The chest tube was clamped. Twenty-four hours later it was removed. This procedure was tolerated well, and the patient went home still on 80 mgm of prednisone daily.

In the subsequent 9 months, there has been no recurrence of the effusion, and presently she is essentially asymptomatic on 15 mgm of prednisone daily.

Previously reported pleural effusions complicating sarcoidosis have responded to systemic corticosteroids. This case suggests that more aggressive therapy may occasionally be required.

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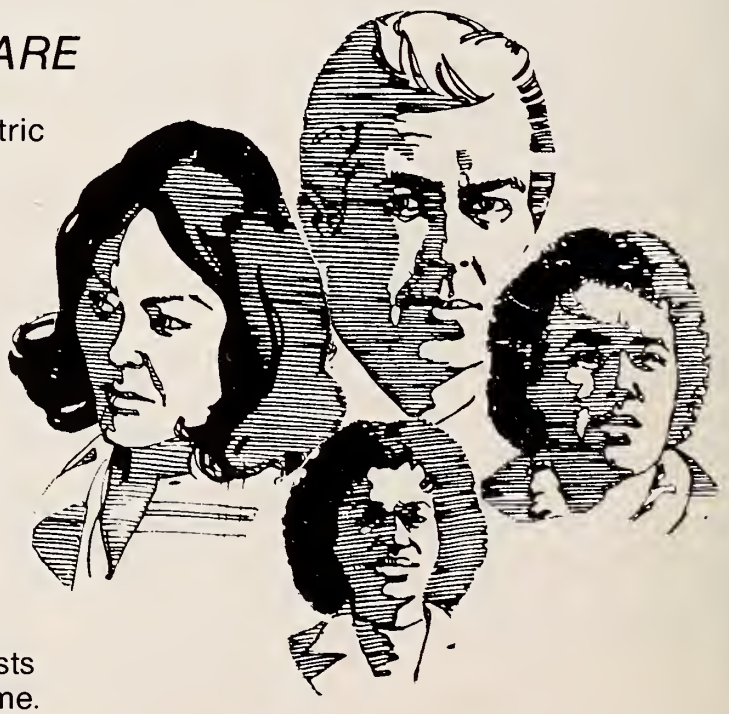
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Rare serious complications of frontal sinusitis may occur in spite of widespread antibiotic usage today.

An Intracranial Complication of Frontal Sinusitis — Case Report

JAMES O. DAY, M.D., *and* CARLOS A. ZEVALLOS, M.D., *Griffin**

Abstract

Meningitis is the most common intracranial complication of frontal sinusitis. Others include subdural empyema, brain abscess, and cavernous sinus thrombosis. A rare case involving the uncommon combination of frank meningitis and subdural empyema is presented, followed by a discussion of diagnosis and management. All physicians should be reminded that rare, serious complications of frontal sinusitis may occur in spite of widespread antibiotic usage today.

INTRACRANIAL COMPLICATIONS of frontal sinusitis, although rare today, may still develop in spite of widespread antibiotic usage. All physicians should be aware of potential complications.

These complications of frontal sinusitis are directly related to the particular bony and vascular anatomy of the frontal sinus. The extremely thin bone separating the posterior frontal sinus and intracranial cavity may allow an infectious process to involve bone and extend into the dural space. Hematogenous spread may also occur across communicating veins into the cranial cavity.[1-3] We present a case of frontal sinusitis complicated by the uncommon combination of meningitis and subdural empyema.

Case Report

A 47-year-old black alcoholic man was admitted to the hospital following a grand mal seizure. There was no history of head trauma or prior seizure activity. The patient complained of a headache upon admission but was too confused to give a reliable history. Physical examination showed a rectal temperature of 100.4 F., blood pressure 190/120. Neurologic examination revealed mental confusion. Fundi showed A-V crossing defects but no hemorrhages, exudates, or papilledema.

Chest x-ray revealed bilateral apical densities. Serum electrolytes and urinalysis were normal. Peripheral white blood cell count was 12,300 with a normal differential count.

After administration of intravenous diphenylhydantoin, the patient was given hydralazine intramuscularly and started on clonidine for his hypertension. On the second hospital day, he became febrile, more confused, and had several more seizures. Nuchal rigidity was also noted. Lumbar puncture revealed an opening pressure of 280 mm and cloudy spinal fluid. Cerebrospinal fluid showed 8,000 white blood cells per mm^3, all polymorphonuclear leukocytes. Spinal fluid glucose was 74 mg.%, protein 104 mg.%, and gram stain showed no organisms. Aqueous penicillin 20 million units and chloramphenicol 4 grams intravenously per day were started immediately pending culture results.

The patient remained very confused and had several more seizures. Respiratory arrest developed on the third hospital day, and he died. Postmortem examination revealed acute frontal sinusitis with localized osteomyelitis and perforation into the cranial cavity. The brain showed diffuse meningitis and subdural empyema confined to the right hemisphere in correlation to the perforation of the right frontal sinus. Also noted was a small pontine hemorrhage. Other findings included inactive pulmonary tubercu-

* Dr. Day is Chief of Medicine; and Dr. Zevallos is Chief of Pathology, Griffin-Spalding County Hospital, Griffin, GA. Send reprint requests to Dr. Day at 231 Graefe St., Griffin, GA 30223. This paper was accepted for presentation at the Southern Medical Association 1984 Scientific Assembly, New Orleans, Louisiana, November 4-7.

losis, and hypertensive myocardial and renal changes. Spinal fluid and postmortem cultures grew *Hemophilus influenzae*.

Discussion

Meningitis is the most common intracranial complication of frontal sinusitis. *Streptococcus pneumoniae, H. influenzae,* other streptococcal strains, and staphylococci are the most common pathogens reported.

Subdural empyema may also follow acute frontal sinusitis and represents at least 20% of all intracranial abscesses.[4] Anaerobic streptococci, bacteroides, staphylococci, and *S. pneumoniae* are the predominant pathogens. Although uncommon, frank meningitis associated with subdural empyema has been reported.[5] Other less common complications include brain abscess and cavernous sinus thrombosis.[1]

Clinical findings suggesting an intracranial complication include severe headache, confusion, high fever and chills, and occasionally frontal and periorbital swelling. Meningeal signs, while present in meningitis, may occasionally be absent in subdural empyema. However, clinical deterioration and appearance of focal neurologic deficits strongly suggest development of subdural empyema. Diagnosis can be very difficult, especially in cases of primary frontal lobe involvement, since this tends to be a very silent area of the brain.

A marked peripheral leukocytosis, although not always present, helps suggest the possibility of an intracranial complication. While spinal fluid cultures are extremely helpful in identifying meningitis, they are usually sterile in subdural empyema. Furthermore, a spinal fluid containing only a few hundred cells per cubic millimeter and a normal glucose level suggests a subdural empyema in contrast to the high cell counts and low glucose levels characteristic in meningitis.[5]

Skull and sinus x-rays can be extremely helpful and can infrequently demonstrate findings such as gas in an abscess cavity. Computerized axial tomography and arteriography are currently considered the most valuable tools in diagnosing subdural empyema and brain abscess.[3, 5, 6]

Proper management of meningitis includes large doses of appropriate intravenous antibiotics, anticonvulsants if seizures are present, and sometimes steroids for increased intracranial pressure. Subdural empyema or brain abscess requires aggressive surgical management for drainage, generally followed with several weeks of antibiotic therapy. Antibiotics considered appropriate because of their ability to penetrate the blood-brain barrier include penicillin G in doses of 20 million units daily, chloramphenicol, and semi-synthetic penicillins. Unfortunately, mortality remains as high as 30 to 50% even in adequately treated cases.[3, 5]

Conclusion

Adequate treatment of frontal sinusitis cannot be overemphasized. Ampicillin usually covers the most likely pathogens and should be continued for 2 full weeks. Erythromycin is a good secondary choice for penicillin allergic patients.[1] When sinus infection fails to resolve on adequate therapy with antibiotics and decongestants, otolaryngology consultation is advised. Signs of an intracranial complication need early recognition and aggressive management. All physicians should be reminded that potential serious complications of frontal sinusitis can still occur even in this age of widespread antibiotic usage.

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This article illustrates several important points that must be considered as medical schools and teaching hospitals respond to the challenge of a doctor surplus.

Physician Surplus and the New Medical Marketplace — Contemporary Challenges to Medical Education

DONALD O. NUTTER, M.D., *Atlanta**

AT THE PRESENT TIME, profound changes are taking place in the United States health care system, and consequently a number of problems confront the medical profession. Two of these issues, the projected surplus of physicians and the new competitive medical marketplace, also present a challenge to our system of medical education and its medical schools and teaching hospitals. This paper will define the issues and challenges and, in turn, enumerate some of the responses that appear to be called for on the part of our academic medical centers.

A Surplus of Physicians

During the 1950s and 60s, the public, medical profession, and federal government all agreed that doctors were in short supply, as well as geographically maldistributed and over-concentrated in certain subspecialties. A vigorous public policy aimed at improving access to health care through increased numbers of physicians, an emphasis on providing primary care, and better geographic distribution of practitioners and facilities resulted from this concern.[1] The policy was implemented, in part, by federal dollars for medical school construction, faculty development, and student aid that were awarded on the basis of student enrollment (capitation). The academic community responded with enthusiasm, and the number of allopathic medical schools increased from 86 to 126 between 1960 and 1980, while osteopathic schools more than doubled from 6 to 14. Medical graduates (MDs and DOs) rose in number from 7500 in 1960 to 16,170 in 1980, and active physicians in the United States increased from 259,500 to 449,500 over the same period. A similar expansion of other health professions schools and practitioners occurred. A new class of nonphysician — health care providers — which included nurse practitioners and physician assistants, was created, and the number of these new practitioners reached approximately 28,000 by the year 1980.

Two recent studies, using differing methods to evaluate physician supply and requirement, have concluded that a surplus of physicians currently exists, and that the situation will be worse in the 1990s and beyond.[2, 3] Calculations of the doctor surplus for the year 2000 range from 32,600 to 145,000 in these studies. There are three critical elements to this problem.

—The enrollment in U.S. medical schools appears to be excessive.
—The inflow of significant numbers of foreign medical graduates, both U.S. citizen and alien, continues.
—Although the geographic and specialty maldistribution of doctors is undergoing correction, partly in response to market forces, residency training positions still appear to be disproportionately distributed between subspecial-

* Dr. Nutter is Executive Associate Dean and Professor of Medicine, Emory University School of Medicine, Atlanta, GA 30322. Send reprint requests to him. This paper was presented at MAG's Leadership Conference Saturday afternoon program, "Training Future Physicians for the Competitive Medical Marketplace," in January, 1984.

ties, so that primary care specialties and certain shortage subspecialties are underrepresented.

Our system of medical education must meet this challenge and provide leadership for the decision making and activities that will be necessary to limit the future supply of physicians and adjust the specialty distribution in training programs.

The declining number of training positions may prove to be the limiting factor on both U.S. and alien FMG entry into the U.S. health care system.

Selected data on the education and supply of doctors presented in the material that follows will serve to illustrate several important points that must be borne in mind as medical schools and teaching hospitals respond to the challenge of a doctor surplus. Foreign-educated doctors have and will continue to play a major role in the delivery of health care in this country.[4] Table 1 contains information on the number and educational background of active physicians in the U.S., and on the sources of supply that maintain this pool of practitioners. The data indicate that approximately 20 percent of our physicians — past, present, and future — are foreign educated, and that the graduates of our osteopathic medical colleges in combination with foreign medical graduates will continue to supply approximately one of five doctors for the U.S. The Graduate Medical Education National Advisory Committee (GMENAC) study estimated that foreign medical graduate (FMG) entry into this country over the next decade will account for more than 50 percent of the projected physician surplus.[2] Table 2 lists the number and distribution by type of medical school of U.S. citizens enrolled as medical students. These data illustrate the importance of including osteopathic schools and their graduates, as well as FMGs, in the development of a manpower policy for the future and in any solutions that are proposed for the problem of doctor surplus. The number of U.S. citizens enrolled in foreign medical schools has increased dramatically over the past decade, and the phenomenon has been uncontrolled and poorly monitored. Despite attrition from the educational process, and the high failure rate on the certifying examination (ECFMG) for residency training in the U.S., the U.S. graduates of foreign medical schools may soon become the most important variable in FMG entry to medical practice in this country since the control of this source may prove to be extremely difficult.[4] Equally important changes are taking place in postgraduate medical education (resident training) as illustrated by the National Resident Matching Program data presented in Table 3. The number of entry-level resident training positions has declined steadily from a high of approximately 22,000 in 1977-78. The first year in which the number of active applicants significantly exceeded the available positions was 1983. The number of U.S. medical school graduates is rapidly approaching the number of available positions, although it appears that approximately 15 percent of graduating seniors do not enter the matching program to compete for these positions. As mentioned above, the number of U.S. foreign medical graduates certified by examination to compete for entry-level residency training is rapidly expanding. Finally, as shown in Table 4, the proportion of postgraduate year 1 training positions allocated to the primary care specialties has steadily increased, although the absolute number of positions has stabilized.

These trends in manpower data support two conclusions that should bear directly on the response of our medical education system to the excess production of doctors. In the first case, if modest reductions in U.S. medical school enrollments, both allopathic and osteopathic, were combined with the elimination or marked curtailment of FMG entry to postgraduate training and practice, we might balance the physician supply/requirement equation in the 1990s or shortly thereafter. The second conclusion deals with the number of resident training positions that undoubtedly will continue to decrease as accreditation criteria become more strict, the support for postgraduate education from third party payers (Medicare) declines or is abolished, and proprietary hospitals with little interest in training increase in numbers. Arbitrary reductions by our academic centers in resident training positions do not appear to be necessary, indeed, care should be taken to match the number of entry-level positions with the projected number of U.S. medical school graduates. At the same time, additional emphasis should be placed on maintaining or increasing the number of positions in the primary care specialties. The declining number of training positions may prove to be the limiting factor on both U.S. and alien FMG entry into the U.S. health care system.

Limiting the Supply of Doctors

To reiterate, limiting the number of physicians that we are training seems to call for at least three responses on the part of our medical schools and academic medical centers: 1) a reduction in medical school enrollment; 2) a reduction in, or the elimination of foreign medical graduates entering residency training programs in our institutions; and 3) the further allocation of training positions to primary care specialties and those subspecialties where shortages are projected, for example, general and child psychiatry, preventive medicine, physical medicine and rehabilitation. The steps required to correct a

TABLE 1 — Active U.S. Physicians and Sources of Physician Supply

	1970	1980	1985*	1990*
Active Physicians (MDs and DOs)				
U.S. Educated	263,200 (81%)	350,100 (78%)	408,200 (78%)	468,000 (79%)
Foreign Educated	59,900 (19%)	99,400 (22%)	115,700 (22%)	123,300 (21%)
TOTAL	323,100	449,500	523,900	591,300
Sources of Physicians†				
MD — U.S. Schools	8,367	15,135	17,400	16,500
DO — U.S. Schools	432	1,035	1,600	1,500
U.S.F.M.G.	198	1,200	1,500	500
Permanent Immigrant MDs	3,158	4,500	2,600	2,500
TOTAL	12,155	21,870	23,100	21,000

* Estimates
† Physicians entering resident training or practice in the indicated year. U.S.F.M.G. = U.S. citizens educated in foreign medical schools. Data source: U.S. Dept. of Health and Human Services, Bureau of Health Professions.

TABLE 2 — U.S. Students Enrolled in Medical School

	1960	1970	1980	1983
U.S. Medical Schools				
Allopathic	30,084 (86)	37,669 (103)	64,195 (126)	66,748 (127)
Osteopathic	1,944 (6)	2,151 (7)	4,544 (14)	> 5,000* (15)
Foreign Medical Schools	2,832	3,426	12,000*	>12,000*

Figures are for total enrollment, ( ) number of schools.
* Estimates.
Data Source: U.S. Dept. of Health and Human Services, Bureau of Health Professionals.

doctor surplus and problems of maldistribution may be obvious, but they will be difficult to accomplish. Our health care system is pluralistic and decentralized, with academic medical centers and schools under the control of state government in some cases, while others function as private, autonomous institutions. The government, the American Medical Association, and/or the Association of American Medical Colleges may recommend appropriate action to reduce the supply of doctors, but it is highly unlikely that legislation will ever mandate action. Responses, for the most part, must be voluntary and each of the proposed steps presents problems for the various institutions involved in medical education.

Measuring and responding to these changing requirements for physicians will compound the already difficult task of formulating new health manpower policy and making adjustments in medical school enrollment and training programs.

Regarding the first step, reductions in medical school enrollment, a new national manpower policy with guidelines based on a coordinated study of physician education, FMG entry, and the training of nonphysician providers would be desirable. In other words, medical school enrollments should be reduced as part of a coordinated activity to control the number of health care providers. By the same token, across the board reductions by all schools at some predetermined level are probably not rational, rather, the requirement for providers should be determined by states or regions and the flow of medical graduates into and away from these areas should be taken into consideration. Other factors must be taken into account, and these include: 1) the impact on medical school budgets — a decrease in enrollment means a significant decrease in unrestricted revenue with little likelihood of an equivalent decrease in expenditures; 2) the potentially adverse effects of reducing enrollment on the access of students from minority groups or disadvantaged socioeconomic backgrounds to medical education and practice — at present these segments of society are underrepresented in the pool of active physicians; and 3) the fact that significant cuts in medical school enrollment and the elimination of USFMG reentry may evoke a strong demand by the public for increased access to medical education.

Manpower policy calling for the elimination of FMG entry to training and practice in this country also poses a major problem, namely, by what method can we accomplish this goal? The most effective approach might be the creation of new policy by State Boards of Medical Examiners that would restrict licensure to graduates of U.S. and Canadian medical schools, with exceptions made for FMGs possessing exceptional skills for which there is a need. This approach would require coordinated action by most or all of the Boards, might give rise to serious legal and moral questions, and seems unlike-

TABLE 3 — National Resident Matching Program

	1980	1981	1982	1983
Entry-Level Positions Offered	18,700	18,034	18,300	17,952
Active Applicants (total)	15,129	16,104	18,410	20,044
U.S.F.M.G. Applicants	655	1,127	1,348	1,988
Graduates U.S. Medical Schools	15,135	15,673	16,012	16,200

Data Source: The National Resident Matching Program.

TABLE 4 — Postgraduate Year One Residents

	1974	1978	1980	1982
Total Positions Filled	18,834	22,291	18,702	18,976
Primary Care* Positions Filled	7,724 (41%)	11,070 (50%)	10,104 (54%)	10,570 (56%)

* Defined as entry-level positions in Family Medicine, Internal Medicine, and Pediatrics. Data Source — American Medical Association.

ly to occur in the near future. Although more difficult certification examinations (for example, the replacement of the VQE and ECFMG exams by the new Foreign Medical Graduate Examination in July, 1984) probably will reduce the number of FMGs qualified to enter residency training, measures of this sort do not promise to achieve a dramatic reduction in FMG entry to this country. Instead, the solution appears to depend on coordinated action by our medical schools and teaching hospitals. Necessary steps will include eliminating the transfer of U.S. citizens from foreign medical schools into the clinical curriculum of U.S. medical schools, abolition of the Fifth Pathway Program, and the refusal of individual institutions to accept FMGs into residency training programs. As mentioned previously, the declining number of entry-level resident positions and the large number of graduates from U.S. medical schools may, in large part, accomplish the latter step. Considerable political pressure to accept USFMGs for training and licensure may be expected from state and federal governments, since many of these students come from the affluent sector of our more populous states. Competing political forces of this sort will complicate the problem. A further caveat is in order. We must take care that policy and action designed to reduce FMG entry for training, licensure, and practice does not compromise the opportunity for selected FMGs, especially those from Third World nations, to receive high quality clinical and research training in this country as preparation for leadership roles in the health care systems of their native countries. To do so would restrict a valuable contribution of our medical education system to world health, as well as causing long-term damage to our country's foreign relations.

Arbitrary reductions in resident training positions would not appear to be a wise approach to limiting the supply of doctors. As previously discussed, the number of positions will continue to decline for a variety of reasons, and the primary concern should be to plan for a balance between entry-level positions and the number of graduates from U.S. medical schools. To do otherwise could result in a number of poorly trained, or even unemployable, practitioners. On the other hand, additional numbers of residency positions should be allocated to the training of primary care practitioners, as well as for specialists in those disciplines projected to have shortages in the future. It is not clear who should or who will make these decisions. At present, decision making resides primarily with individual academic programs and centers, but a strong argument for central planning at the level of state or federal government can be made. Several important questions remain unanswered, and these include: 1) how much primary care is enough? 2) who should provide primary care — generalists, subspecialists, and/or nonphysician providers? and 3) what are the best methods of training primary care physicians? Our academic medical centers may be able to provide some answers to these questions through continued health services research.

All of this presents our academic medical centers with a challenge to adapt their curricula and process of medical education to meet the needs of both students and the new marketplace.

Rapidly occurring changes in the delivery and financing of health care are creating a new medical marketplace with the emphasis on competition and for-profit services.[5, 6] These changes may significantly alter the requirement for physicians and other health professionals in the future. Measuring and responding to these changing requirements for physicians will compound the already difficult task

of formulating new health manpower policy and making adjustments in medical school enrollment and training programs. In addition, and of at least equal importance, the new medical marketplace will surely dictate changes in medical curricula and methods of education.

A New Competitive Medical Marketplace

The several key elements that characterize the change taking place in our health care system can be summarized as follows:

—Patients are seeking and using, and in some cases payers are recommending, new modes of health care service such as: ambulatory care centers for varied purposes (surgery, urgent care, hemodialysis), home health services, and prepaid comprehensive care plans.
—Health care financing is rapidly shifting from cost-based reimbursement to prospective payment arranged through a variety of mechanisms, for example, the Medicare DRG system.
—Relationships between providers and payers, and between various providers (physician groups and hospitals), are changing to emphasize contractual arrangements for the cost-effective delivery of care. A second purpose of new contractual relations is to maintain or develop provider control over groups of patients, and to create patterns of patient flow from health care plans or physician groups to hospitals.
—American medicine is undergoing a "corporate transformation" that includes a major component for for-profit health care. It appears that this will lead to the growth of large conglomerates that will employ large numbers of health professionals, operate vertically organized inpatient and outpatient facilities, and control a wide range of subsidiary industries.
—The process is transforming physicians from their current status as autonomous professionals into corporate employees, and, in many cases, doctors are becoming entrepreneurs in the corporate, for-profit system that is emerging.

All of this presents our academic medical centers with a challenge to adapt their curricula and process of medical education to meet the needs of both students and the new marketplace.

Educating Tomorrow's Corporate Physician

The primary responsibility of undergraduate medical education and postgraduate training is to provide future doctors with a comprehensive biomedical science base, a knowledge of disease processes, and the basic clinical skills they will need to deliver high quality health care, as well as to imbue them with the desire to become lifelong learners. In this sense, nothing has changed. There are, however, other educational needs that must be satisfied if we are to graduate and certify young doctors who are capable of contributing to and providing leadership for the changing health care system. The list of new challenges to medical education is not yet complete, but it seems clear that the following topics and issues must be addressed as we prepare doctors and other health professionals for a place in the new market.

—Medical students and house officers must understand the U.S. system of health care — how it has been structured and operated, and the direction in which it is now moving. They must learn how health policy is made and implemented, in order that they may influence policy in the future.

These trends in manpower data support two conclusions that should bear directly on the response of our medical education system to the excess production of doctors.

—Faculties must prepare students for the new image and role that doctors are assuming, and they must provide information on the evolving arrangements for medical practice. This calls for significant clinical education and training in ambulatory, primary care activities, as well as exposure to the new types of ambulatory care facilities. Faculty role models in primary care and preventive medicine are needed in significant numbers to balance against student exposure to the high technology, subspecialty medicine that is practiced in the tertiary care facilities usually found in academic medical centers.
—Students must be introduced to the economics of health care and encouraged to take an active role in cost containment, while striving to maintain quality of care. In most cases, the subject of cost containment cannot be taught in the classroom, rather, it requires the use of clinical examples, computer simulations, and reinforcement by faculty members during daily clinical teaching activities.
—Students must learn an analytic approach to medical practice that is based on scientific method and is emphasized in both the preclinical and clinical years. This approach should include the critical use of medical literature, technology assessment, and clinical decision analysis, and probably is best taught through problem solving with clinical examples.
—Finally, students must be made aware of and provided with some insight into the expanding

range of ethical dilemmas that face today's practitioner. In addition to the moral dilemmas created by new medical technology, medical educators must highlight the potential conflict of interest that will be inherent in the professional and business aspects of medical practice in the new, for-profit oriented market. In this context, values and commitments of medical students that will lead them to serve as advocates for persons who will experience difficulty accessing health care in the new marketplace (the poor, disabled, aged, and uninsured) should be nurtured and rewarded.

Medical schools are not comfortable with many of these new educational responsibilities. Considerable planning and testing of curricular materials and teaching techniques will be necessary before most academic medical centers can meet the challenge provided by the changes occurring in medical practice. In this regard, community physicians and professional organizations can be valuable resources for academic faculties and institutions. A stronger partnership between practicing physicians and the academic community must be forged if the medical profession is to respond in a timely fashion and provide leadership for the new health care system.

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A new physician curriculum in CPR has been developed to answer the valid objections raised by many practitioners concerning the old CPR teaching format, and the response has been overwhelmingly favorable.

Physician Participation in Cardiopulmonary Resuscitation Training

JOHN E. FORESTNER, M.D., *Atlanta**

Methods for cardiopulmonary resuscitation (CPR) were devised to maintain the neurologic integrity of the central nervous system following sudden cardiac death until definitive therapy could be provided. Ventilatory support with mouth-to-mouth breathing and circulatory assistance with closed chest massage could be supplied immediately at the scene of an arrest. Because no special equipment was required and techniques were relatively simple, individuals with no medical background could be trained to resuscitate until emergency services could be summoned.

The commitment to train the lay public in cardiopulmonary resuscitation was made at an early stage of development of this program by both the American Heart Association and the American Red Cross. This was prompted by data indicating that the majority of deaths due to cardiovascular disease occur outside the hospital in the first hour after onset of symptoms.[1] It was realized that any significant decrease in mortality due to sudden cardiac death would have to be obtained by initial bystander CPR, which would require training of large segments of the population, to be followed by rapid response emergency medical teams providing definitive therapy with oxygen, resuscitative drugs, and defibrillation when appropriate. Where such an approach has been developed and implemented, as in Seattle, Washington, an impressive record of successful resuscitations in the field has been reported.[2] Most areas of the country cannot equal the 25% of the population trained in CPR, or the 4-minute EMS response time, which appear to be significant factors in the Seattle system responsible for improving survival following out-of-hospital arrest. Thus, recent trends indicating a decrease in cardiovascular mortality in our society are more likely due to risk factor modification and better long-term medical care than to the impact of resuscitation systems now in operation.[3]

Physicians have played an essential role in the development of cardiopulmonary resuscitation, from the earliest research in animals, through the testing of techniques in hospitals and in the field, to the final recommendations for uniform methods to be taught throughout the society.[4, 5] Physicians are responsible for continuing research to investigate possible improvements in CPR routines, although the essential technical details have remained basically unchanged for over a decade. Physicians have also had a central role in setting up emergency medical systems, establishing protocols for field resuscitations by paramedics, and supervising the delivery of care and transport to the hospital under radio telemetry. Following hospital admission, the supervision of resuscitations is properly assigned to the physician in charge.

Yet despite considerable physician input into the development and implementation of the CPR program, their involvement recently seems to be rapidly declining. Within Georgia and around the country,

* Dr. Forestner is Assistant Professor, Department of Anesthesiology, Emory University School of Medicine, and Chairman, Emergency Cardiac Care Committee, Georgia Affiliate, American Heart Association. Send reprint requests to him at the Henrietta Egleston Hospital for Children, Inc., 1405 Clifton Rd., NE, Atlanta, GA 30322.

fewer physicians are being trained in cardiopulmonary resuscitation, and physician participation at the instructor level is minimal, even within the hospital setting. The physician's function in CPR education at the community level has been assumed by the nurse educator, the emergency medical technician, and by non-medically trained volunteers. Because the CPR training effort has expanded so broadly and so rapidly, has the physician become superfluous? The fact that the American Red Cross and American Heart Association basic life support training systems function quite well without much physician input would imply that this is indeed true.

Lack of physician involvement in basic cardiopulmonary resuscitation training in Georgia is easily documented, and many factors which interfere with their participation can be defined. It can be compellingly argued that all physicians should have established competence in the performance of basic CPR, despite evidence that the majority of medical practitioners in Georgia have neither achieved this goal nor maintained their skills. A training system designed specifically to teach physicians basic cardiopulmonary resuscitation is being introduced and is intended to overcome some of these obstacles and increase the number of physicians who can effectively perform CPR.[6, 7] By informing physicians of the availability of this program and providing some of the details of its format, it is hoped that this review can serve to stimulate improved medical participation in CPR training within the state.

Decreasing Physician Involvement in Cardiopulmonary Resuscitation

The CPR training system is divided into basic and advanced levels of instruction. Basic Cardiac Life Support (BCLS) includes all rescue maneuvers which can be performed by non-medical personnel and require no special equipment. Techniques which are taught include mouth-to-mouth ventilation and closed chest massage, positioning maneuvers to open the upper airway, and various methods for clearing foreign bodies from the obstructed airway. Provider certification involves single rescuer and two rescuer methods, infant resuscitation, and obstructed airway treatment. Basic provider students attend a background lecture which includes a demonstration of resuscitation methods. They then practice these techniques on mannequins, and following demonstration on their part of correct performance of the resuscitation routines, they take a short multiple choice test. BCLS certification usually takes from 4-8 hours for individuals with no medical background, but nurses and physicians can be expected to finish training in around 4 hours. While the Heart Association and Red Cross use different teaching methods in BCLS, the information taught and the testing process are essentially the same.

Table 1 — Physician CPR Training, Henrietta Egleston Hospital For Children, Atlanta, Georgia 1979-1983

Year (September-August)	*Courses Given*	*Physicians Certified*
1979-80	8	114
1980-81	5	72
1981-82	3	42
1982-83	2	31

Note: A minimum number of courses were scheduled each year, and additional courses were added in response to telephone requests from members of the medical staff. Telephone requests for CPR training decreased significantly after September, 1980.

The Heart Association also offers a shorter review of single rescuer CPR, called the Heartsaver course, which can be taught in 1-2 hours. The only testing consists of a demonstration of the single rescuer technique by the student. While this is an ideal format for community CPR teaching, this approach has also been adapted in many hospitals for rapid physician instruction.

Over 70,000 Georgia citizens received BCLS certification under the American Red Cross and American Heart Association systems between September 1982 and August 1983. While this represents an increase in the number of individuals trained in CPR relative to previous years, examining the training records at most hospitals would indicate that the actual number of physicians receiving CPR instruction has steadily been decreasing over the past few years. In one Atlanta area hospital where physician CPR courses are scheduled on a regular basis, with additional courses given in response to phone requests made to the medical staff secretary, such requests for training, the number of courses held, and the number of physicians certified have decreased each year over the past 4 (Table 1).

In 1978, the Joint Commission on Accreditation of Hospitals (JCAH) began to require that all hospital staff physicians receive training in CPR, and enforcement of this provision greatly increased the numbers of physicians certified in subsequent years. Hospitals established physician CPR programs to meet this requirement and to assure maintenance of accreditation. By 1980, however, the JCAH had reconsidered its position and announced it would no longer enforce this CPR requirement. The rationale offered was that most physicians seldom performed resuscitations on a regular basis and that those who frequently were involved in CPR should and would seek appropriate training on their own.[8] The fact that the CPR requirement had been politically unpopular and difficult to enforce was undoubtedly a factor in this decision. For whatever reason, this change in JCAH policy resulted in sharp declines in physicians receiving CPR instruction, as reflected in data from

Table 2 — Physician Involvement in Basic Cardiac Life Support (BCLS) Teaching, Fulton and Dekalb Counties, 1983, and State of Georgia, 1983

Fulton and DeKalb Counties, 1983	*Total BCLS Training Personnel*	*Physicians*
BCLS Instructors	429	8
BCLS Instructor Trainers	37	0
BCLS Affiliate Faculty	9	2
State of Georgia 1983		
BCLS Affiliate Faculty	71	5

around the State of Georgia and the entire country. Presumably, those hospitals who retained the CPR requirement in their medical staff bylaws did not experience this decrease, but most hospitals immediately revised their regulations to conform with the JCAH.

The basic life support program of the Georgia Affiliate of the American Heart Association keeps computerized records of all volunteers involved in teaching CPR, training CPR instructors, and administering the program at the community level. Review of these records demonstrates that very few physicians are involved as instructors or administrators within the BCLS program in the Atlanta area or around the state[9] (Table 2). Lack of qualified physician BCLS instructors compounds the difficulty of attracting physicians into CPR training courses, because many or most physicians expect to be instructed by a fellow physician and resent teaching and testing from the nurse educators, paramedics, or lay volunteers who are most often available to conduct these programs. Despite the fact that these non-physician instructors are well trained and competent, the reluctance of many physicians to assume a subsidiary role to para-professional personnel teaching CPR is as regrettable as it is understandable.

The biggest objection to CPR training is the time commitment involved — the pace of the courses is too slow, the didactic content is often too elementary, and the teaching slides are embarrassingly unsophisticated.

A great deal of physician volunteer time is diverted from the BCLS program into the Advanced Cardiac Life Support program of the American Heart Association, for which there is no American Red Cross counterpart. Training courses in ACLS take at least 2 days and cover resuscitation skills which require special equipment, such as endotracheal intubation, electrocardiographic assessment of rhythm disturbances, pharmacologic therapy of cardiac arrest, and defibrillation. The course is offered only to physicians, nurses, and paramedical personnel who will utilize these methods in their daily work. Each course must have a physician specially trained as an ACLS instructor as the medical director, and physician input into each course should be extensive. Prior training in BCLS is required for all participants in ACLS courses because basic resuscitation skills are considered the foundation on which all advanced techniques must be based. Still, the BCLS and ACLS training systems are essentially separate in most communities, and physician involvement in the teaching of basic life support remains minimal.

Why Physicians Should Learn Cardiopulmonary Resuscitation

The ability to perform cardiopulmonary resuscitation adequately must be acquired through training. It is not an ability instinctively possessed by the physician, nor is it automatically included in the medical school degree. As recently as 1980, less than half the medical schools in this country required CPR training as part of the curriculum.[10] Retention of CPR skills by physicians after they complete a formal course is poor at 1 year, whether or not they participate in resuscitations on a regular basis.[11-13] Therefore, at a minimum, physicians should be recertified yearly to assure optimal results when they treat victims of cardiac arrest.

Persuasive arguments can be offered about why physicians should be trained in cardiopulmonary resuscitation.[10] Most importantly, the physician swears by his oath to sustain life whenever he is able, and as a means of accomplishing this end, he should be prepared to employ CPR techniques. As suggested by Dalen et al.,[10] other compelling reasons are related to the widespread training of the general population in CPR. A general awareness has developed that cardiac arrest is not absolutely equated with death. Failure on the part of a physician to begin CPR promptly for a cardiac arrest victim may be interpreted as negligence by observers and could potentially lead to litigation. Furthermore, because performance standards are the same for lay persons as for physicians, incorrect methods of CPR applied by physicians may be noted by non-professional bystanders, who having been trained in resuscitation realize that poor technique may affect outcome. Ambulance attendants and hospital nurses are required by their employers to learn cardiopulmonary resuscitation, making those physicians without adequate training the weakest link in the emergency care system. Physicians have been challenged when attempting to assist paramedics in treating cardiac victims in the field, and in one instance have even been prosecuted for interfering with a resuscitation and resisting arrest.[14] Obviously the credibility and competence of physicians in emergency medical

care is being seriously questioned, but not without good reason, however, given the number of practitioners with inadequate resuscitation skills.

Why Physicians Do Not Receive CPR Training

The reasons that physicians do not take part in CPR training are for the most part valid, and these objections must be answered before these practitioners will be attracted into future courses. Some physicians point out that they seldom act as first responders to an arrest and almost never participate in resuscitations. When one compares patients seen by the family practitioner with those treated by emergency physicians, cardiologists, or trauma surgeons, different levels of resuscitation activity are to be expected; but when we urge the general population to learn CPR techniques, we must also recognize that any physician has a much higher probability than the layperson of encountering a cardiac arrest in his work, regardless of his specialty. If we teach boy scouts, civic clubs, and church groups CPR, can we reasonably exempt the physician?

The biggest objection to CPR training is the time commitment involved, because even courses designed specifically for physicians may take 4 hours or more to complete. Physicians complain that the pace of the courses is too slow, the didactic content is often too elementary, and the teaching slides are embarrassingly unsophisticated. Personnel teaching these courses are most often nurses from the education or staff development departments of hospitals who are qualified and experienced CPR instructors. Still, many physicians feel uncomfortable receiving instruction from non-physicians and resent being tested for certification by nurses or emergency technicians.

For the busy practicing physician, these reasons may make CPR training unattractive or impossible. By designing an instruction format to accommodate physicians and their special needs, and to answer their objections outlined above, a new BCLS for Physicians course has recently been developed by the Subcommittee on Emergency Cardiac Care of the American Heart Association. It is hoped that this new curriculum, which is described below, will make cardiopulmonary resuscitation training more attractive and reasonable to the physicians who desire CPR certification.

The New CPR for Physicians Course

The didactic content of this new course begins with a sophisticated review of mechanisms of sudden cardiac death, emphasizing risk factors and lifestyle modification, with clear illustrations summarizing the most current statistics on cardiovascular disease. Technical performance of CPR is then covered both in slide presentation and with hands-on mannequin practice. The student-instructor ratio is kept low, ideally 2:1, to minimize demonstration and practice time. A 50 question multiple choice examination is then given, followed by testing of CPR techniques on the mannequins. Physicians may also elect to certify at the Heartsaver level during the course by taking a shorter written examination and by demonstrating only the one man rescue technique. An additional but optional review of medicolegal aspects of resuscitation is also included in both the textbook and in the teaching slides. This medicolegal section invariably generates considerable discussion among the course participants and may add to the length of the session. Therefore, it is usually preferable to cover this topic following testing for any interested course participants. It is also possible to extend the session with an introduction to advanced cardiac life support techniques as a means of attracting physicians into future courses.

Failure on the part of the physician to begin CPR promptly for a cardiac arrest victim may be interpreted as negligence by observers and could potentially lead to litigation.

Three pilot courses involving over 60 physicians were conducted in Georgia as part of a series of 50 given throughout the country. These courses were given at the Medical College of Georgia in Augusta, South Fulton County Hospital, and the Henrietta Egleston Hospital for Children in Atlanta. The response to the new curriculum among Georgia physicians and among over 1000 physicians throughout the country was overwhelmingly favorable. The time commitment for training was around 3 hours for physicians being certified for the first time, and 1-2 hours for recertifying physicians. This is at least 25% shorter than previously reported times for physician CPR training.[12] The didactic content of the course and the audiovisual format were also judged appropriate by physician participants. Following minor revisions, the Basic Life Support for Physicians manual and an accompanying Instructor Manual have been published by the American Heart Association, and these are available along with the teaching slides from the Georgia Affiliate office.

The curriculum requires that a physician be involved as the director of each course, and for reasons cited above it is preferable that as many physicians as possible be included as instructors. Given the scarcity of qualified physician CPR instructors in Georgia, the course faculty will still consist primarily of nursing personnel until more physicians become involved in the CPR program. One desirable result of this new physician curriculum would be an

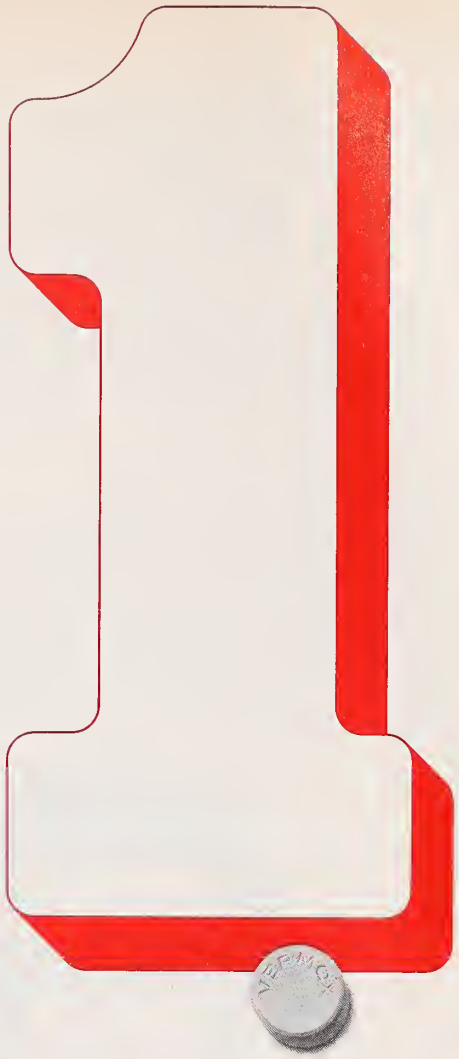
increase in physician interest in CPR training both at the provider and the instructor level, but it is much too early to adequately assess the eventual impact of the program on physician involvement.

Summary

Physician involvement in cardiopulmonary resuscitation training has been impeded by numerous factors. A new physician curriculum in cardiopulmonary resuscitation has been developed to answer the valid objections raised by many practitioners concerning the old CPR teaching format. By developing a course directed specifically to the needs of the busy practicing physician, it is hoped that greater medical involvement in resuscitation will result and that an improvement in emergency cardiac care can be facilitated.

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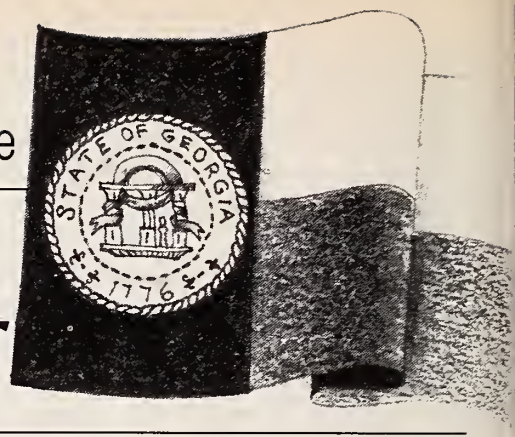
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Dr. Crawford W. Long

One of the most important discoveries in medicine was the use of ether in surgical procedures, and its revelation was delayed because of the inordinate modesty of Dr. Crawford W. Long, its first successful user.

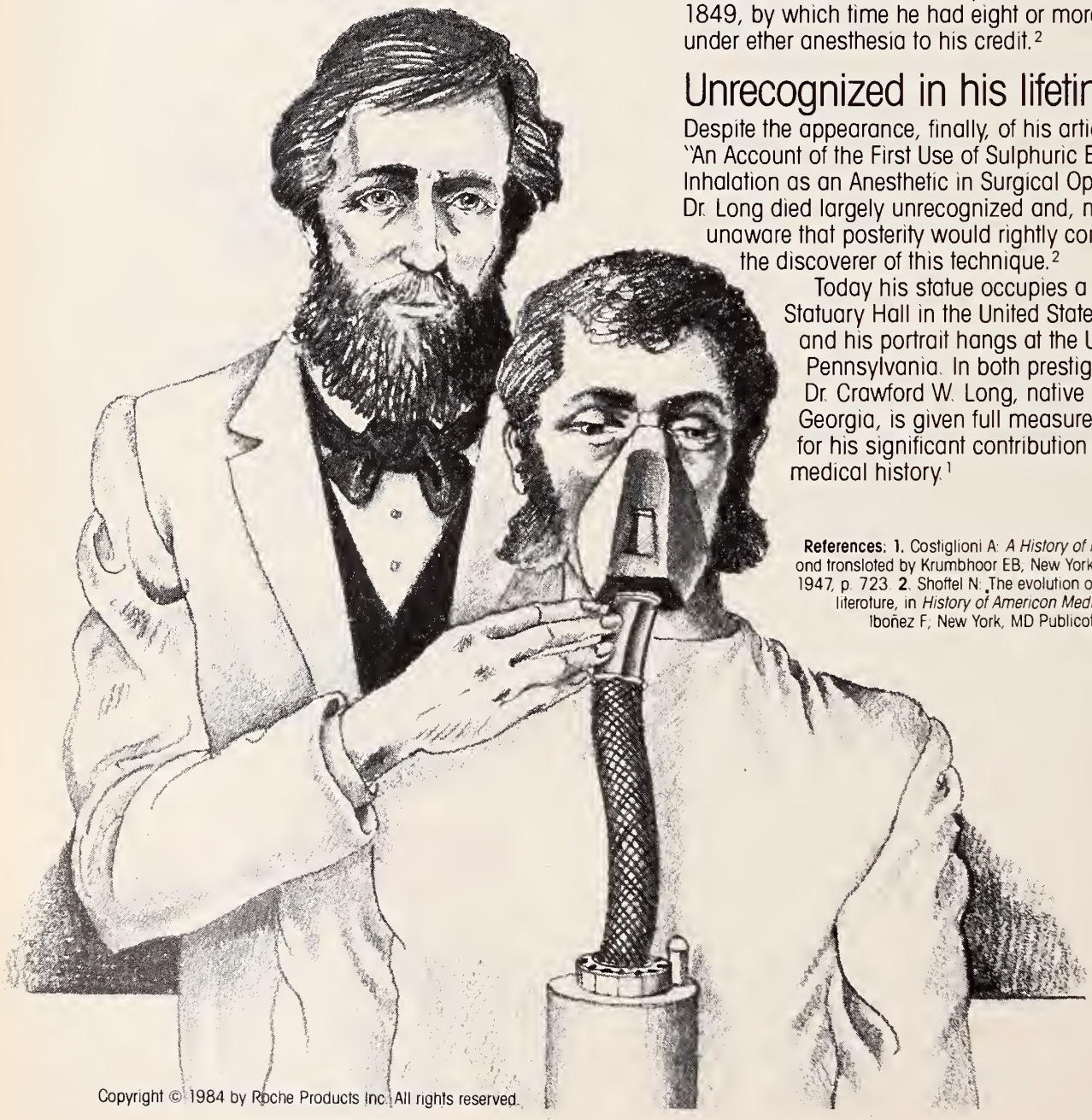
A simple country practitioner in Jefferson, Georgia, Dr. Long had little surgical experience when, on March 30, 1842, he experimented with the use of sulfuric ether as an anesthetic in the surgical removal of a small septic tumor from the neck of a patient. The patient, James Venable, reported feeling no pain during the incision and removal proceedings, and soon recovered.[1,2]

Pleased by the results of surgery under anesthesia, Dr. Long continued to use ether in surgery and obstetrics. Recognition for his accomplishment was limited, however, because he did not publish his discovery until 1849, by which time he had eight or more operations under ether anesthesia to his credit.[2]

Unrecognized in his lifetime

Despite the appearance, finally, of his article titled "An Account of the First Use of Sulphuric Ether by Inhalation as an Anesthetic in Surgical Operations," Dr. Long died largely unrecognized and, most assuredly, unaware that posterity would rightly consider him the discoverer of this technique.[2]

Today his statue occupies a place in Statuary Hall in the United States Capitol, and his portrait hangs at the University of Pennsylvania. In both prestigious locations, Dr. Crawford W. Long, native son of Georgia, is given full measure of respect for his significant contribution to medical history.[1]



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Warnings: Use with great care in patients with history of urinary retention or angle-closure glaucoma. Severe constipation may occur in patients taking tricyclic antidepressants and anticholinergic-type drugs. Closely supervise cardiovascular patients. (Arrhythmias, sinus tachycardia and prolongation of conduction time reported with use of tricyclic antidepressants, especially high doses. Myocardial infarction and stroke reported with use of this class of drugs.) Caution patients about possible combined effects with alcohol and other CNS depressants and against hazardous occupations requiring complete mental alertness (*e.g.*, operating machinery, driving).

***Usage in Pregnancy:* Use of minor tranquilizers during the first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.**

Since physical and psychological dependence to chlordiazepoxide have been reported rarely, use caution in administering Limbitrol to addiction-prone individuals or those who might increase dosage; withdrawal symptoms following discontinuation of either component alone have been reported (nausea, headache and malaise for amitriptyline; symptoms [including convulsions] similar to those of barbiturate withdrawal for chlordiazepoxide).

Precautions: Use with caution in patients with a history of seizures, in hyperthyroid patients or those on thyroid medication, and in patients with impaired renal or hepatic function. Because of the possibility of suicide in depressed patients, do not permit easy access to large quantities in these patients. Periodic liver function tests and blood counts are recommended during prolonged treatment. Amitriptyline component may block action of guanethidine or similar antihypertensives. Concomitant use with other psychotropic drugs has not been evaluated, sedative effects may be additive. Discontinue several days before surgery. Limit concomitant administration of ECT to essential treatment. See Warnings for precautions about pregnancy. Limbitrol should not be taken during the nursing period. Not recommended in children under 12. In the elderly and debilitated, limit to smallest effective dosage to preclude toxic, oversedation, confusion or anticholinergic effects.

Adverse Reactions: Most frequently reported are those associated with either component alone: drowsiness, dry mouth, constipation, blurred vision, dizziness and bloating. Less frequently occurring reactions include vivid dreams, impotence, tremor, confusion and nasal congestion. Many depressive symptoms including anorexia, fatigue, weakness, restlessness and lethargy have been reported as side effects of both Limbitrol and amitriptyline. Granulocytopenia, jaundice and hepatic dysfunction have been observed rarely.

The following list includes adverse reactions not reported with Limbitrol but requiring consideration because they have been reported with one or both components or closely related drugs:

Cardiovascular: Hypotension, hypertension, tachycardia, palpitations, myocardial infarction, arrhythmias, heart block, stroke.

Psychiatric: Euphoria, apprehension, poor concentration, delusions, hallucinations, hypomania and increased or decreased libido.

Neurologic: Incoordination, ataxia, numbness, tingling and paresthesias of the extremities, extrapyramidal symptoms, syncope, changes in EEG patterns.

Anticholinergic: Disturbance of accommodation, paralytic ileus, urinary retention, dilatation of urinary tract.

Allergic: Skin rash, urticaria, photosensitization, edema of face and tongue, pruritus.

Hematologic: Bone marrow depression including agranulocytosis, eosinophilia, purpura, thrombocytopenia.

Gastrointestinal: Nausea, epigastric distress, vomiting, anorexia, stomatitis, peculiar taste, diarrhea, black tongue.

Endocrine: Testicular swelling and gynecomastia in the male, breast enlargement, galactorrhea and minor menstrual irregularities in the female, elevation and lowering of blood sugar levels, and syndrome of inappropriate ADH (antidiuretic hormone) secretion.

Other: Headache, weight gain or loss, increased perspiration, urinary frequency, mydriasis, jaundice, alopecia, parotid swelling.

Overdosage: Immediately hospitalize patient suspected of having taken an overdose. Treatment is symptomatic and supportive. I.V. administration of 1 to 3 mg physostigmine salicylate has been reported to reverse the symptoms of amitriptyline poisoning. See complete product information for manifestation and treatment.

Dosage: Individualize according to symptom severity and patient response. Reduce to smallest effective dosage when satisfactory response is obtained. Larger portion of daily dose may be taken at bedtime. Single *h.s.* dose may suffice for some patients. Lower dosages are recommended for the elderly.

Limbitrol 10-25, initial dosage of three or four tablets daily in divided doses, increased up to six tablets or decreased to two tablets daily as required. Limbitrol 5-12.5, initial dosage of three or four tablets daily in divided doses, for patients who do not tolerate higher doses.

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Georgia's Representation at the AMA Unprecedented

On June 19, 1984, I was named President-Elect of the American Medical Association by the House of Delegates. I would like to express my gratitude for your support.

Back in 1976, the MAG delegation to the AMA House of Delegates, with the help of the late Dr. J. W. (Red) Chambers, gave counsel and support in my initial race for the AMA Council on Medical Service. I was defeated in this effort but did have the opportunity to gain exposure at a national level.

Our delegation subsequently decided that I should offer for the office of Vice Speaker the following year — and committed the MAG to a full effort. The 1977 Annual Meeting was held in San Francisco. We were blessed with a large number of Georgia doctors and their wives who worked hard in the strategy and work sessions along with MAG staff. The competition was tough but our team worked hard, and we ultimately won. I was elected Vice Speaker and served from 1977 to 1981 under Dr. William Rial as Speaker.

When Dr. Rial ran for President-Elect, I was unopposed in my race for Speaker of the House and subsequently was elected each year without opposition.

Being named President-Elect of the AMA is certainly the pinnacle of my professional career and reflects credit on the MAG as well. Georgia has had two previous AMA Presidents: Dr. H. F. Campbell, of Augusta, in 1885, and Dr. James E. Paullin, of Atlanta, in 1943. We are also fortunate this year to have three Georgia doctors on the AMA Board of Trustees. I have been an ex officio member since 1977 without a vote and with my election this year have now gained a vote. Dr. William Dowda won a seat on the Board in 1982. This year the newly created position of Resident Physician Trustee was won by Dr. Ron Davis, a Fellow at the Centers for Disease Control in Atlanta. The Resident Trustee position is with full voting privileges. Thus, Georgia physicians have unprecedented representation at the AMA with six delegates and alternates, two trustees and the President-elect.

I am grateful for your support and pledge my very best efforts in behalf of our patients and our profession. Please write or call if you have problems, and I'll work to solve them. A major thrust of my term in office will be to increase AMA membership across the country and especially in Georgia. Please help by encouraging AMA membership of all our colleagues.

Harrison L. ("Jack") Rogers, Jr., M.D.
President-elect, AMA
1938 Peachtree St. NW, #601
Atlanta, GA 30309

Paul Revere's Midnight Ride (Apathy and the Demise of Medical Associations)

Why do we have the Medical Association of Georgia? What are our purposes? What are our goals?

The Medical Association of Georgia is the only organization that represents all of us: the practicing physician, the academician, the public health physician, the emergency room physician, the administrator physician, etc. It is mandatory that it remain strong and viable. Apathy and lack of support by its members would be deadly and soon produce its demise. "United we stand — divided we fall!"

It is essential that we have your attendance and support at the Scientific Assembly. This will insure the survival of our association. You and the citizens of Georgia will be the benefactors!

Scientific meetings are for the purpose of communication, friendships, and cross fertilization of ideas among the participants. We have a major forum for the physicians of Georgia — the Annual Scientific Assembly. If it fades into oblivion because of lack of support, it will be a disgraceful black mark on us, lowering our high esteem. This must not happen!

I am now on Paul Revere's "Midnight Ride." The lanterns are lighted!

Ellis B. Keener, M.D.
Chairman, Committee on Scientific Assembly
430 Washington St.
Gainesville, GA 30501

Broadening Georgia's Medical Malpractice Litigation Statute

BASIL ZIRINIS, *Atlanta**

THE DRAMATIC INCREASE in the mid-1970s in the number and severity of medical malpractice claims not only resulted in sharply rising malpractice insurance rates (i.e., the so-called "medical malpractice crisis"), but also led numerous states to enact reform legislation designed to discourage the filing of baseless malpractice claims. One of the most significant types of reform legislation adopted in many states involved the creation of pretrial screening panels or arbitration boards as an alternative to, or as an optional or required procedural step before, costly and time-consuming jury trials.

Generally, pretrial screening panels are designed to provide an impartial, non-binding assessment of the validity of a plaintiff's claim. The use of these panels usually is called for by statute and is mandatory in most states in which they exist. The majority of these states allow the panel's findings to be introduced into evidence at a subsequent trial. While the panel's holding is not binding, it is supposed to encourage the settlement of claims. The binding arbitration board, by contrast, substitutes for the court and renders a decision which has the same force as a court's holding.

Ideally, the use of pretrial screening panels and arbitration boards benefit both sides of a malpractice dispute. For example, arbitration proponents argue that it provides speedier handling of claims (which in turn may lower legal expenses for both parties), decreases unreasonable awards by eliminating over-emotional jurors, and lessens publicity. The arbitration board is usually made up of experienced decision-makers who may be experts in the particular field of controversy, which allows for relaxed rules of evidence and reduces the need for costly expert witnesses. Studies have confirmed that arbitration does work more quickly and economically than litigation.[1]

At the same time, however, opponents of arbitration argue that it may encourage nuisance claims, that sophisticated arbitrators view damages *too* dispassionately, and that the arbitration process may lead to compromise jusgments rather than clear determinations of fault.[2]

Georgia presently has an arbitration statute for use in resolving medical malpractice disputes. This statute, however, is extremely narrow; there are no provisions for pretrial screening panels or mandatory arbitration, and voluntary agreements to arbitrate are authorized only in limited circumstances. This month's Legal Page takes a brief look at Georgia's present arbitration statute, as well as at recent court

* Prepared at the request of the Medical Association of Georgia. Mr. Zirinis attends Columbia University School of Law and is a summer associate in the firm of Powell, Goldstein, Frazer & Murphy, General Counsel to the Association, 1100 C & S National Bank Building, Atlanta, GA 30335.

decisions in other states which appear to indicate that Georgia's law, constitutionally, could be a good deal more expansive.

Georgia's Malpractice Arbitration Statute

In 1978, the Georgia General Assembly chose to take a narrow approach to malpractice arbitration.[3] An enacted, the malpractice arbitration statute makes no provision for pretrial screening and authorizes agreements to arbitrate only if the agreement is made *subsequent* to the alleged malpractice, only *after* a dispute has occurred, and only if the patient or other claimant is represented by an attorney at the time the agreement is entered into.

Arbitration is a purely voluntary procedure in Georgia which involves a number of steps:

(1) After the parties agree in writing to arbitrate, they must file a petition with a superior court for an order authorizing arbitration and for the appointment of a referee and reporter. The reporter attends the hearings and records the testimony and proceedings.[4]

(2) The referee must be an attorney and is a non-voting member of the arbitration panel. With the referee's assistance, the parties prepare a "submission," which sets out the matters in controversy, an agreement as to the payment of costs, the arbitration procedures, the names of the arbitrators chosen by each party, and other pertinent matters.[5]

(3) Each party chooses one member of the arbitration panel, and a third member is named by the first two. If the original two arbitrators cannot agree on a third, the judge who authorized the arbitration appoints the third member.[6]

(4) Both parties have the same rights to discover evidence as in civil cases, and the referee has the power to compel the attendance and testimony of witnesses and the production of documentary evidence.[7]

(5) The arbitration panel makes written findings on each of the matters in controversy; the concurrence of any two of the three arbitrators on the panel on a finding is sufficient to constitute *the* finding of the panel on that issue.[8]

(6) All findings are final and conclusive as between the parties, unless appeal is made to the superior court. The court may set aside the arbitrators' findings of fact only if the findings were procured by fraud, are contrary to law, or there is no evidence to support them.[9]

In short, medical malpractice arbitration in Georgia is not mandatory; it is a voluntary procedure which can be agreed to by the parties only *after* a dispute has arisen, and only after certain prerequisites have been met.

Expanding the Scope of Statutory Arbitration in Georgia

It appears that Georgia's arbitration statute need not be so limited in scope. Recent cases have shown that, if properly drafted, statutes providing for pretrial screening panels or pre-treatment arbitration agreements will survive constitutional challenge. Either or both of these approaches might be considered by the Georgia General Assembly.

Constitutionality of Pretrial Screening Panels

A statute providing for pretrial screening panels would typically require that all medical malpractice claims be submitted to a panel for a review and findings on the issues of liability or damages (or both) before proceeding to trial. A panel usually consists of several professionals with experience in either law or medicine. Because these panels are designed, among other things, to encourage settlement, the panel's findings usually are admissible as evidence at a subsequent trial.

Screening panels have been challenged as a denial of the constitutional rights of access to the courts, of trial by jury, of equal protection of the laws, and of due process. Judicial analysis of these challenges generally has turned on the specific details of the statutory provisions.[10]

Using these cases as a guide, it appears that so long as the jury remains the

ultimate fact-finder — that is, as long as the admission of the panel's findings is treated as merely one source of evidence — and as long as the findings are admitted only if unanimous, the various constitutional challenges will fail. The courts that have upheld such statutes have stressed the historic independence of juries, the ability of jurors to ascribe appropriate weight to the panel's findings, and the important state interest of alleviating the malpractice crisis.[11]

Constitutionality of Pre-Treatment Arbitration Agreements

Agreements to arbitrate *future* malpractice disputes and legislation regulating such agreements have been attacked on the same constitutional grounds as screening panels and also as ''adhesion contracts.'' An ''adhesion contract'' is a standardized form contract offered to consumers of goods and services on a ''take-it-or-leave-it'' basis without affording the consumer a realistic opportunity to bargain, and under such conditions that the consumer cannot obtain the desired services except by acquiescing to the form contract. Adhesion contracts are often written in language confusing to the consumer, so that the consumer may not realize what is actually being agreed to.

In recent years, courts have consistently rejected constitutional challenges to arbitration statutes authorizing binding pre-treatment malpractice arbitration agreements. Most recently, the Supreme Court of Michigan ruled that the Michigan Medical Malpractice Arbitration Act was constitutional;[12] Michigan's law is therefore an appropriate example of how Georgia might successfully structure a more expansive arbitration statute.

The Michigan Arbitration Act authorized a patient to execute an agreement, *in advance,* to arbitrate *any* medical malpractice dispute arising from treatment by a specific medical provider, before a three-member arbitration panel consisting of one attorney, one physician or hospital administrator, and one independent party. A patient signing such a contract could revoke it within 60 days after execution, or, in the case of an arbitration agreement with a hospital, within 60 days after discharge. This right of revocation was required to be explicitly included in the contract, as was a statement that the agreement to arbitrate was not a prerequisite to the receipt of health care services. The agreement also was required clearly to inform the patient that arbitration was a substitute for trial by jury.

To the Michigan Supreme Court, such a contract was not violative of the patient's constitutional rights. It was not an adhesion contract because it was not a requirement for receiving health care and could be rescinded within 60 days. The arbitration provisions were clear and conspicuous and the patient was given a meaningful opportunity to decide whether to relinquish his or her constitutional rights to court access and trial by jury.

The plaintiff in the Michigan case also raised an interesting and novel question concerning the composition of the arbitration panel — she argued that the composition of the arbitration panel was unconstitutionally biased and deprived her of the constitutional right to an impartial decision-maker, in that any hospital administrator or physician would have a substantial interest in the outcome of the arbitrated case because the cost and availability of medical malpractice insurance would be affected. The Court agreed that the medical member of the board was a member of a class which would be affected by the decision, but held that such a link was not enough to violate due process. Rather, the Court found that a direct, personal, pecuniary interest which created a probability of unfairness must exist in order to support a finding that the statute was unconstitutional, and that no such probability existed simply because of the arbitrator's status as a physician or hospital administrator.

Conclusion

At present, Georgia's arbitration statute is quite narrow in scope — it neither mandates the use of pretrial screening panels nor authorizes a physician and patient to enter into a binding pre-treatment malpractice arbitration agreement. Recent

cases in other jurisdictions indicate, however, that more expansive arbitration statutes are constitutionally permissible. Thus, it may be appropriate for the Georgia General Assembly to consider enacting an expanded arbitration statute, one which either mandated pretrial screening panels or encouraged arbitration by permitting agreements to arbitrate to be made prior to treatment and before a dispute arose.

Notes

1. *See, e.g.,* Sokayan, *Arbitration and Screening Panels: Recent Experiences and Trends,* 17 Forum 682 (1982).
2. *Id.*
3. Official Code of Georgia Annotated §9-9-110 et seq.
4. O.C.G.A. §9-9-112.
5. O.C.G.A. §§9-9-115, 9-9-116.
6. O.C.G.A. §9-9-117.
7. O.C.G.A. §§9-9-122, 9-9-124.
8. O.C.G.A. §9-9-128.
9. O.C.G.A. §9-9-130.
10. *See, Comiskey v. Arlen,* 55 App. Div. 2d 304, 390 N.Y.S.2d 122 (1976); *Whitaker v. St. Joseph's Hospital,* 415 N.E.2d 737 (Ind. App. 1981); *but see Wright v. Central Du Page Hospital Association,* 63 Ill.2d 313, 347 N.E.2d 736 (1976), where an Illinois statute creating a medical review panel was held to unconstitutionally confer a judicial function on the non-judicial members of the panel.
11. *Id.;* see, generally, "An Analysis of State Legislative Responses to the Medical Malpractice Crisis," Duke Law Journal, Vol. 1975, No. 6, pp. 1417-1468; Annotation, 80 A.L.R.3d 583 (1977).
12. *Morris v. Metriyakool,* 418 Mich. 423, 344 N.W.2d 736 (1984).

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MEPROBAMATE: DRUG DEPENDENCE: Physical and psychological dependence, and abuse have occurred. Chronic intoxication from prolonged ingestion of, usually, greater than recommended doses is manifested by ataxia, slurred speech, and vertigo. Therefore, carefully supervise dose and amounts prescribed and avoid prolonged use, especially in alcoholics and others with known propensity for taking excessive quantities of drugs. Sudden withdrawal after prolonged and excessive use may precipitate recurrence of preexisting symptoms, e.g. anxiety, anorexia, or insomnia, or withdrawal reactions, e.g., vomiting, ataxia, tremors, muscle twitching, confusional states, hallucinosis, and, rarely, convulsive seizures. Such seizures are more likely in persons with CNS damage or preexistent or latent convulsive disorders. Onset of withdrawal symptoms occurs usually within 12 to 48 hours after discontinuation; symptoms usually cease within next 12- to 48-hour period. When excessive dosage has continued for weeks or months, reduce dosage gradually over 1 to 2 weeks rather than stop abruptly. Alternatively, a short-acting barbiturate may be substituted, then gradually withdrawn.

POTENTIALLY HAZARDOUS TASKS: Warn patients meprobamate may impair mental or physical abilities required for potentially hazardous tasks, e.g., driving or operating machinery.

ADDITIVE EFFECTS: Since CNS-suppressant effects of meprobamate and alcohol or meprobamate and other psychotropic drugs may be additive, exercise caution with patients taking more than one of these agents simultaneously.

USAGE IN PREGNANCY AND LACTATION:
An increased risk of congenital malformations associated with minor tranquilizers (meprobamate, chlordiazepoxide, and diazepam) during first trimester of pregnancy, has been suggested in several studies. Because use of these drugs is rarely a matter of urgency, their use during this period should almost always be avoided. The possibility that a woman of childbearing potential may be pregnant at time of institution of therapy should be considered. Advise patients if they become pregnant during therapy or intend to become pregnant to communicate with their physicians about desirability of discontinuing the drug.

Meprobamate passes the placental barrier. It is present both in umbilical-cord blood at or near maternal plasma levels and in breast milk of lactating mothers at concentrations two to four times that of maternal plasma. When use of meprobamate is contemplated in breastfeeding patients, consider the drug's higher concentrations in breast milk as compared to maternal plasma levels.

USAGE IN CHILDREN: Keep preparations with aspirin out of reach of children. Equagesic® (meprobamate with aspirin) is not recommended for patients 12 years of age and under.

PRECAUTIONS:
ASPIRIN: Salicylates antagonize uricosuric activity of probenecid and sulfinpyrazone. Salicylates are reported to enhance hypoglycemic effect of sulfonylurea antidiabetics.

MEPROBAMATE: Use lowest effective dose, particularly in elderly and/or debilitated, to preclude over-sedation. Meprobamate is metabolized in the liver and excreted by the kidney, to avoid excess accumulation exercise caution in its use in patients with compromised liver or kidney function. Meprobamate occasionally may precipitate seizures in epileptic patients. It should be prescribed cautiously and in small quantities to patients with suicidal tendencies.

ADVERSE REACTIONS:
ASPIRIN: May cause epigastric discomfort, nausea, and vomiting. Hypersensitivity reactions, including urticaria, angioneurotic edema, purpura, asthma, and anaphylaxis may rarely occur. Patients receiving large doses of salicylates may develop tinnitus.

MEPROBAMATE: CNS: Drowsiness, ataxia, dizziness, slurred speech, headache, vertigo, weakness, paresthesias, impairment of visual accommodation, euphoria, overstimulation, paradoxical excitement, fast EEG activity.

GI: Nausea, vomiting, diarrhea.

CARDIOVASCULAR: Palpitation, tachycardia, various forms of arrhythmia, transient ECG changes, syncope, hypotensive crisis.

ALLERGIC OR IDIOSYNCRATIC: Milder reactions are characterized by itchy, urticarial, or erythematous maculopapular rash, generalized or confined to the groin. Other reactions include leukopenia, acute nonthrombocytopenic purpura, petechiae, ecchymoses, eosinophilia, peripheral edema, adenopathy, fever, fixed drug eruption with cross-reaction to carisoprodol, and cross-sensitivity between meprobamate/mebutamate and meprobamate/carbromal. Rare, more severe hypersensitivity reactions include hyperpyrexia, chills, angioneurotic edema, bronchospasm, oliguna, and anuria. Also, anaphylaxis, exfoliative dermatitis, stomatitis, and proctitis. Stevens-Johnson syndrome and bullous dermatitis have occurred.

HEMATOLOGIC (SEE ALSO "ALLERGIC OR IDIOSYNCRATIC"): Agranulocytosis, aplastic anemia have been reported, although no causal relationship has been established, and thrombocytopenic purpura.

OTHER: Exacerbation of porphyric symptoms.

DOSAGE AND ADMINISTRATION:
Usual dose is one or two tablets, 3 to 4 times daily as needed for relief of pain when tension or anxiety is present. Not recommended for patients 12 years of age and under.

OVERDOSAGE:
Treatment is essentially symptomatic and supportive. Any drug remaining in the stomach should be removed. Induction of vomiting or gastric lavage may be indicated. Activated charcoal may reduce absorption of both aspirin and meprobamate. Aspirin overdosage produces usual symptoms and signs of salicylate intoxication. Observation and treatment should include management of hyperthermia, specific parenteral electrolyte therapy for ketoacidosis and dehydration, watching for evidence of hemorrhagic manifestations due to hypoprothrombinemia which, if it occurs, usually requires whole-blood transfusions. Suicidal attempts with meprobamate have resulted in drowsiness, lethargy, stupor, ataxia, coma, shock, vasomotor and respiratory collapse. Some suicidal attempts have been fatal. The following data, reported in the literature and from other sources, are not expected to correlate with each case (considering factors such as individual susceptibility and length of time from ingestion to treatment), but represent usual ranges reported. Acute simple overdose (meprobamate alone). Death has been reported with ingestion of as little as 12 grams meprobamate and survival with as much as 40 grams.

BLOOD LEVELS:
0.5-2.0 mg percent represents usual blood-level range of meprobamate after therapeutic doses. The level may occasionally be as high as 3.0 mg percent.

3-10 mg percent usually corresponds to findings of mild-to-moderate symptoms of overdosage, such as stupor or light coma.

10-20 mg percent usually corresponds to deeper coma, requiring more intensive treatment. Some fatalities occur.

At levels greater than 20 mg percent, more fatalities than survivals can be expected.

Acute combined overdose (meprobamate with other psychotropic drugs or alcohol): Since effects can be additive, history of ingestion of a low dose of meprobamate plus any of these compounds (or of a relatively low blood or tissue level) cannot be used as a prognostic indicator.

In cases of excessive doses, sleep ensues rapidly and blood pressure, pulse, and respiratory rates are reduced to basal levels. Any drug remaining in stomach should be removed and symptomatic treatment given. Should respiration or blood pressure become compromised, respiratory assistance, CNS stimulants, and pressor agents should be administered cautiously as indicated. Diuresis, osmotic (mannitol) diuresis, pentoneal dialysis, and hemodialysis have been used successfully in removing both aspirin and meprobamate. Alkalinization of the urine increases excretion of salicylates. Careful monitoring of urinary output is necessary, and caution should be taken to avoid overhydration. Relapse and death, after initial recovery, have been attributed to incomplete gastric emptying and delayed absorption.

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The Cyanotic Newborn: Keys to Early Diagnosis and Emergency Management

FREDERICK W. ARENSMAN, M.D., *Augusta**

Abstract

There have been many recent advances in the diagnosis and therapy of congenital heart disease. An essential and often underemphasized first step in the successful treatment of these infants is to recognize that a cardiac problem exists. At the Medical College of Georgia, more than 80% of the newborns with congenital heart disease are referred from outlying hospitals. These infants can receive appropriate therapy only after heart disease is suspected by the primary physician and rapid referral is made.

The purpose of this paper is to: a) provide helpful information to the general practitioner or pediatrician for the early recognition of congenital cyanotic heart disease; b) outline an appropriate initial diagnostic evaluation which should begin at the referring hospital; and c) discuss therapy which should be initiated prior to transfer for definitive diagnosis and treatment.

Introduction and Definition

THE INCIDENCE of congenital heart disease is 8-10/1000, or approximately 1% of all live births.[1] The highest mortality is in the neonatal period.[2] Until the last 15 to 20 years, about 30% of these with congenital heart disease died when they were less than 1 month old.[2] The majority of patients presenting in the *neonatal* period are cyanotic.[3] This blue discoloration occurs when the concentration of reduced hemoglobin in the blood is 5 grams/100cc or more. Cyanosis is described as "central" when the mucous membranes are involved and *usually* implies systemic hypoxemia from either a cardiac or pulmonary cause. Table 1 lists a more complete differential diagnosis for central cyanosis. Regardless of the etiology, central cyanosis is always pathologic in the newborn and requires immediate attention and prompt diagnostic evaluation and therapy.

Diagnosis

History

The accurate, rapid determination of the etiology of central cyanosis depends on assimilation of data from the history, physical examination, and laboratory test

* Dr. Arensman is Assistant Professor of Pediatrics at the Medical College of Georgia, Augusta, GA 30912. Send reprint requests to him.

Articles for this page are sponsored and approved by the American Heart Association, Georgia Affiliate. Those wishing to contribute papers to this Page are invited to send them to Dr. Laurence O. Watkins, "Heart Page" Editor, Section of Cardiology, Dept. of Medicine, MCG, Augusta, GA 30909.

Table 1 — Causes of Cyanosis

By assigning the causes of cyanosis to different organ systems, the practitioner can usually determine the etiology of central cyanosis. Appropriate laboratory evaluation will rule out polycythemia, hypoglycemia, and methemoglobinemia.

- **I. Respiratory**
  - **A. Mechanical**
    1. **Choanal atresia**
    2. **Tracheobronchial fistula**
    3. **Tracheoesophageal fistula**
    4. **Pneumothorax, pneumomediastinum**
    5. **Diaphragmatic hernia**
    6. **Lobar emphysema**
    7. **Hypoventilation (usually Central Nervous System disease)**
  - **B. Parenchymal**
    1. **Hyaline membrane disease**
    2. **Aspiration**
    3. **Pneumonia**
    4. **Pulmonary hemorrhage**
- **II. Cardiac**
  - **A. Right to Left Shunt at**
    1. **Atria**
    2. **Ventricles**
    3. **Great vessels**
    4. **PDA**
    5. **TAPVR (Atria)**
  - **B. Poor Cardiac Output**
    1. **Hypoplastic left heart**
    2. **Aortic atresia**
    3. **Coarctation**
- **III. Central Nervous System (All secondary to hypoventilation)**
    1. **Hemorrhage**
    2. **Malformation**
    3. **Infection**
    4. **Seizure**
    5. **Edema**
- **IV. Miscellaneous**
    1. **Polycythemia**
    2. **Hypoglycemia**
    3. **Methemoglobinemia**
    4. **Shock or sepsis**
    5. **Drugs, CNS depression**
    6. **Neuromuscular (Werding-Hoffman)**

results. Once central cyanosis is detected, the physician should quickly obtain the following data:

Time of onset — Early cyanosis is most common with congenital defects. Cyanosis beginning several days after birth is often associated with an acquired problem.

Family history — This may be helpful if it is positive for neuromuscular disease or if there are siblings with congenital heart disease.

Gestational age — Premature infants have a higher incidence of hyaline membrane disease and may become cyanotic because of pulmonary dysfunction. However, this may not be the only reason for central cyanosis. The old adage that prematurity and congenital heart disease are mutually exclusive is false.

Physical Examination

The physical examination is often helpful and should not be limited to the cardiovascular system. The respiratory pattern may suggest the cause of the cyanosis. A cyanotic infant with apnea or bradypnea frequently has a central nervous system disorder. The child with unlabored tachypnea or "Happy Tachypnea" often has cardiogenic cyanosis. Tachypnea associated with retractions and

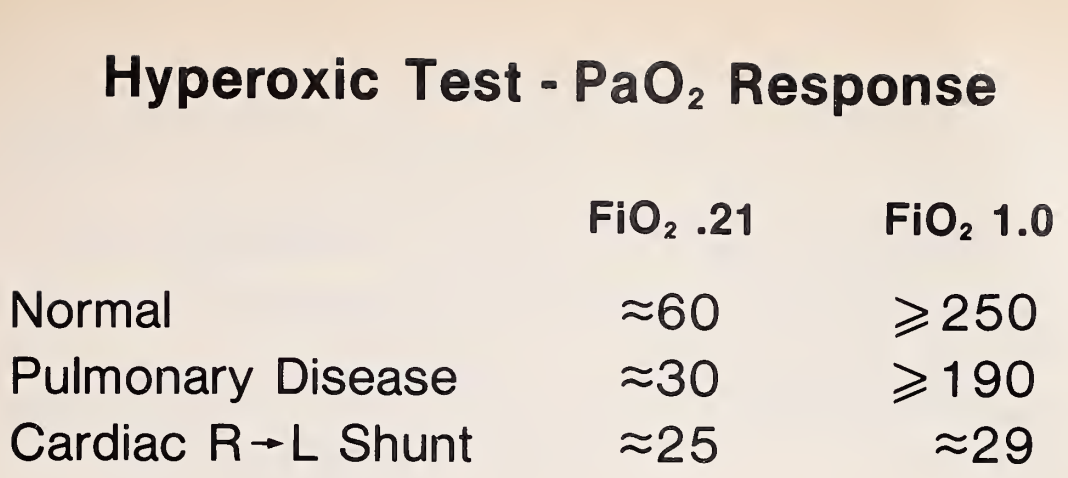


Figure 1 — Hyperoxic Test PaO_2 Response: When alveolar oxygen concentration approaches 100%, the normal infant has an arterial PaO_2 of about 250 TORR. If there is intrinsic lung disease, the response to oxygen may be blunted, but the PaO_2 should be greater than 150 TORR. If obligate right-to-left shunting is present, the PaO_2 is less than 150 TORR and usually varies little from values obtained in room air.

grunting may indicate a respiratory problem such as hyaline membrane disease or meconium aspiration. The child with methemoglobinemia usually has a normal respiratory pattern.

The abdominal examination could be helpful. A scaphoid abdomen could indicate a diaphragmatic hernia which allows displacement of bowel or liver into the thoracic cavity. Hepatomegaly may indicate congestive heart failure. A diaphragmatic hernia could reduce the functioning lung volume and result in pulmonary right to left shunting.

Cardiac examination often does not yield the diagnosis; however, the following should be carefully recorded: heart rate, intensity and location of precordial impulses, the presence and intensity of pulses and blood pressure in both an upper and lower extremity. The intensity of heart sounds should be evaluated, and an attempt should be made to determine whether the second heart sound is single or split. A single second heart sound in an infant more than 24 hours old suggests one of the following: a. severe stenosis or atresia of a semilunar valve; b. abnormal semilunar valve position (transposition of the great arteries); or c. the presence of one large semilunar valve (truncus arteriosus). The timing, location, intensity, and transmission of murmurs should be evaluated. An important caveat is that:

All heart murmurs are not pathologic.
All pathologic conditions do not have murmurs.

Laboratory Evaluation

There are only a few laboratory tests required in *all* children with central cyanosis. These can be done within 30 minutes and should not prevent the expeditious transfer of the child to a tertiary care facility. In addition to providing valuable data in the diagnosis of the underlying problem, these tests are helpful in evaluating the need for initial therapy prior to and during the child's transfer.

Blood should be examined to exclude methemoglobinemia. This important and often overlooked examination requires only one drop of blood and can be lifesaving. Methemoglobinemia results in a chocolate color of the venous blood after exposure to room air. Polycythemia (Hct>70%), which may result in central cyanosis and require treatment by partial exchange transfusion, can be ruled out by hemoglobin and hematocrit determination. Serum glucose is occasionally low in cyanotic infants. Hypoglycemia may occur in the presence of heart failure[3] or cyanosis[4] and rarely may be indirectly responsible for cyanosis. Infants of diabetic mothers are predisposed to polycythemia, hypoglycemia, and cyanosis. The serum

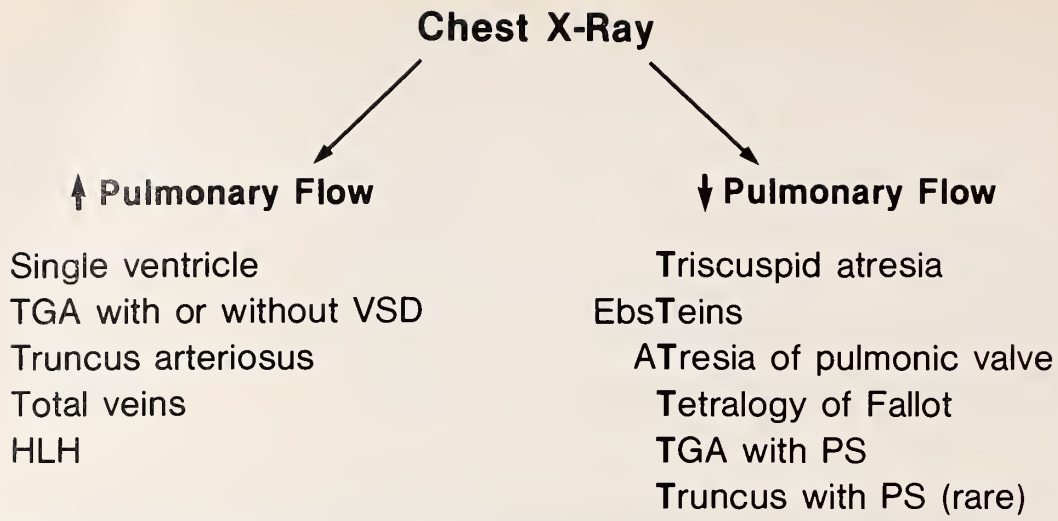


Figure 2 — Chest X-ray Evaluation of Pulmonary Flow in Cyanotic Congenital Heart Disease: TGA = transposition of the great arteries; Total veins = Total anomalous pulmonary venous return; HLH = Hypoplastic left heart; PS = Pulmonic stenosis. The abnormalities listed under increased flow have bidirectional shunting. The lesions with decreased flow have predominantly right to left shunting.

glucose should be maintained at ≥ 35mg/dl. Blood gas concentrations and pH are helpful in determining the etiology of cyanosis. Cyanosis of pulmonary origin (excluding intrapulmonary right-to-left shunting) usually results in low arterial pO_2 and normal or slightly increased pCO_2. Hypoxemia secondary to hypoventilation or intrinsic pulmonary disease usually resolves when the baby inspires 100% oxygen. The usual response is an increase in the arterial pO_2 to about 350 TORR. Persistently low values or minimal increase during this "Hyperoxic Test" implicates right-to-left shunting at cardiac or (rarely) pulmonary locations. It is important that blood be sampled from the right upper extremity to prevent confounding by right-to-left shunting at the level of the ductus arteriosus. The hyperoxic test is not completely reliable in the presence of severe meconium aspiration, hyaline membrane disease, or persistent pulmonary hypertension. Some authors have suggested the use of a bag and mask to provide positive airway pressure and 100% oxygen to increase the likelihood of high alveolar oxygen saturation[5] (Figure 1).

Both anteroposterior and lateral chest x-rays should be obtained on all infants with unexplained cyanosis. Barium swallow and oblique projections chest radiographs do not usually provide additional information. Evaluation of pulmonary blood flow on chest x-ray is helpful in assigning the problem to one of two groups associated with either increased or decreased pulmonary vascular markings (Figure 2). The chest x-ray is also useful for detecting or excluding non-cardiac causes of cyanosis such as hyaline membrane disease, pulmonary parenchymal disease, esophageal atresia, diaphragmatic hernia, pneumothorax, or pneumomediastinum. Cardiomegaly (cardio-thymic ratio > 60/100) is helpful in identifying intrinsic cardiac disease or cardiac enlargement secondary to hypoglycemia, hypoxia, hypervolemia, or polycythemia. The absence of cardiomegaly does not, however, exclude life-threatening cardiac disease.

Referral and Transportation

Once congenital heart disease is suspected, immediate communication with the pediatric cardiologist at a tertiary center should begin. When central cyanosis is detected, the referring physician should contact the pediatric cardiologist or neonatal nursery to which referral will be made. While transportation is being arranged, the initial diagnostic evaluation can begin.

Stabilization

Prior to transfer, the neonate should have a functioning intravenous line. If the serum glucose, serum calcium, and blood pH are abnormal, efforts to correct them

Table 2 — Ductal Dependent Congenital Heart Disease

When obstruction to pulmonary or systemic flow is suspected, prostaglandin E_1 may be indicated. Maintaining ductal patency may improve pulmonary or systemic flow. A major side-effect of prostaglandin E_1 is apnea. (See text.)

Ductal Dependent Congenital Heart Disease

I. Ductal dependent pulmonary flow

A) Pulmonary atresia
B) Pulmonary stenosis
C) Tetralogy of Fallot
D) Tricuspid atresia
E) Ebstein's anaomly of the tricuspid valve
F) Hypoplastic right ventricle

II. Ductal dependent systemic flow

A) Aortic arch interruption
B) Coarctation
C) Hypoplastic left heart

should begin prior to transport. The local physician should inform the parents of the emergent need for transport, explain the need for catheterization, and give them the name of the pediatric cardiologist into whose care the child is being transferred. Informed consent for catheterization and possible surgery should be obtained. It is important that the parents see and touch the baby prior to transfer. A sample of maternal blood should accompany the infant so that blood for subsequent transfusion can be screened.

In infants with critical pulmonic stenosis or atresia or tricuspid atresia, virtually all pulmonary flow occurs via the ductus arteriosus. When these abnormalities are suspected, special efforts are required to maintain ductal patency. Intravenous infusion of prostaglandin E_1 at 0.05-0.10 micrograms per kilogram per minute has been helpful in achieving this goal. Side effects of PGE_1 include apnea, fever, flushing, and muscle twitching. If prostaglandin infusion is begun prior to transfer, the nurse or physician in attendance should be prepared to recognize and treat apnea. The use of prostaglandins has increased the safety of catheterization because metabolic acidosis is at least partially corrected and the PO_2 is increased. In addition, there is less urgent need for the surgical placement of a systemic-to-pulmonary arterial shunt. Table 2 lists the anatomic abnormalities in which PGE_1 may be helpful.

In addition to its use in cyanotic heart disease, PGE_1 infusion can be utilized to maintain systemic flow when coarctation or interruption of the aortic arch is present.

(Continued on p. 635)



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The Present Status of Management of Primary Breast Cancer

P. KEN DIXON, M.D., *Gainesville**

BREAST CANCER will effect one out of every 11 women. In the United States, there will be approximately 115,000 cases of breast cancer diagnosed this year, and 1,900 of these will be in Georgia. It is the most common cancer in the female, and, fortunately, has always been one of the cancers that can be cured in a large percentage of patients if diagnosis is early and treatment appropriate. The traditional method of treatment from the early 1900s until recent times has been the radical mastectomy. However, over the last 15 years, the radical has given way, in large part, to the modified radical mastectomy. In the modified procedure, the breast and axillary contents are removed, but one or both pectoral muscles are preserved, thereby leaving a more cosmetic chest wall contour and improved functional result. In Georgia in 1970, 90% of the mastectomies done were radical mastectomies. Now, about 90% are modified. Nearly all surgeons will concur in saying that this decrease in the extent of surgery has been with no sacrifice in local control or survival rates. Thus, the modified radical mastectomy has become well established as the standard method of irradication of operable breast cancer today. However, there is presently a strong trend toward using even less extensive surgery. In this article, I would like to examine this push toward breast conservation surgery.

New Treatment Options

The present clash over treatment for primary breast cancer is regarding the question of whether or not most of the breast can be preserved while removing only the part around the breast cancer. Basically, the proposed "conservative" surgical approaches are two. In one, the lump itself with only a small margin of surrounding breast tissue is removed. This is the so called "lumpectomy." In the other, a more generous resection of breast tissue is removed around the tumor, resulting in a "quadrantectomy" or "segmental mastectomy." In both of these, the axillary contents should always be removed, either through the same or a separate incision. (This should be done, if not for purposes of local control, at least for determination of nodal status, so that decisions regarding adjuvant chemotherapy can be made.)

In the United States, removal of part of the breast first created a stir in the 1950s when George Crile, Jr., of the Cleveland Clinic reported favorable results with "partial mastectomy" for small breast cancers. The fact that he was not averse to discussing his treatment plans in the *Ladies Home Journal* resulted in a wave of criticism about partial mastectomy in the medical community. This is in spite of the fact that he did recommend partial mastectomy only for very favorable lesions and

* Dr. Dixon practices general surgery. Send reprint requests to him at 669 Lanier Park Dr., NE, Gainesville, GA 30505.

Prepared at the request of the Georgia Division, American Cancer Society. Others wishing to contribute papers to this Page are invited to send them to T. Gray Fountain, MD, 910 N. Jefferson, Albany, GA 31708.

continued to use the modified radical mastectomy for most breast carcinomas. Nevertheless, over the ensuing 2 decades, he and other individuals and institutions have continued to offer such conservative treatment in selected instances. Over the last several years, Dr. Crile's initial favorable results in the "conservative" management of breast cancer have been reinforced by other studies. However, another variable is usually entered into this equation, in that frequently radiation therapy has been used in order to insure adequate local control rates. Usually, the radiotherapy is in the range of 4500 to 6000 rads given post-operatively to patients after the primary tumor mass is excised. The radiotherapy may be given completely by external beam techniques or may be partly by external beam and supplemented by radioactive implants, such as Iridium. Therefore, the question is not limited to whether local resection alone is adequate. There is also the question of whether local resection in combination with radiation is adequate. In fact, most studies of local excision of primary breast cancers have included radiation therapy. These studies have been almost always of selected Stage I carcinomas (those less than 2 cm. and with no palpable axillary adenopathy). Occasionally, some Stage II carcinomas (those with tumors between 2 and 5 cm. or those with palpable axillary nodes) have been so treated.

Results

What have the results been with these techniques? In general, comparisons of survival and local control rates between mastectomy and local excision plus radiotherapy have shown no major differences. However, the criticism has been leveled repeatedly that these studies in which most of the breast is preserved are of highly selected patients and are therefore not comparable to most series of mastectomies, in which all patients with operable breast carcinoma are included. Only one study, that of Veronesi and colleagues in Italy, has been a prospective and randomized study. It compared radical mastectomy with local tumor excision plus radiotherapy in several hundred patients. No significant difference in local recurrence or survival rates was demonstrated.

The Push to Change

The many studies that promote local excision and radiotherapy in selected groups of patients have certainly made their mark. The study by Veronesi goes further in challenging the modified radical mastectomy. However, the conclusion of most surgeons dealing with breast cancer has been that inadequate data are back yet to recommend any large scale change in treatment.This continued acceptance of the "tried and true" mastectomy is under increasing pressure. Publicity of breast preservation has been building at an ever increasing rate. Many radiotherapists feel that local excision plus post-operative radiotherapy provides results that are equal to mastectomy. Samuel Hellman, a prominent Boston radiotherapist, and now Physician-in-Chief of Memorial Sloan Kettering Hospital, has been vocal and articulate in disseminating his view, as have many other radiotherapists. Conferences on breast cancer with titles such as "Alternatives to Mastectomy in Breast Cancer Treatment" are demonstrative. Similarly, Hellman and Silen have just published a book entitled, *Conservative Management of Breast Cancer*. The push toward change, though, seems to be evolving at a more rapid pace due to the attention of the lay media. Every few days an article or commentary appears in newspapers, magazines, or on TV about breast preservation surgery. This pressure by the public in bringing changes to bear in surgical treatment is without precedent. A former breast cancer patient presents her view in *New York Magazine,* in which she says, "The battlelines are drawn: Surgeons against Radiotherapists, Women against Surgeons." Thus, surgeons tend to be increasingly viewed as the black hats in this conflict.

As a surgeon, my personal approach has been to continue recommending the modified radical mastectomy as the treatment of choice. However, I do discuss the option of local excision plus axillary dissection plus post-operative radiotherapy in

those patients in whom I feel this is a viable alternative, based on the data now available. A major reservation that I have about local excision and radiation is the fact that around 30% of patients who are felt to have an N_O axilla will turn out to have positive nodes. In these patients, the treatment plan becomes complex in trying to decide how to utilize adjuvant chemotherapy and radiotherapy and in what sequence. Additionally, the possibility of tumor recurrence in the residual breast tissue is a concern that has not yet been fully laid to rest.

Future Study

The author of the article mentioned above in *New York Magazine* states that "until clinical trials settle the issue, the debate will continue." Presently, a multi-institutional trial by the NSABP (National Surgical Adjuvant Breast Project) is ongoing. This is a prospective randomized trial of Stage I and Stage II carcinomas of the breast. This study will be a three-armed study comparing: (1) mastectomy and axillary dissection; (2) segmental mastectomy and axillary dissection; and (3) segmental mastectomy, axillary dissection, and post-operative radiotherapy. Patients are still being accepted into this study, and the preliminary results are still a few years away. Many are awaiting the results of this study and, without doubt, its results will have a marked effect on the treatment of primary breast cancer in the United States. Until that time, I believe most surgeons will continue to recommend modified radical mastectomy as the safest way to insure maximal local control and survival rates.

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Heart Page — Continued from p. 631

Conclusion

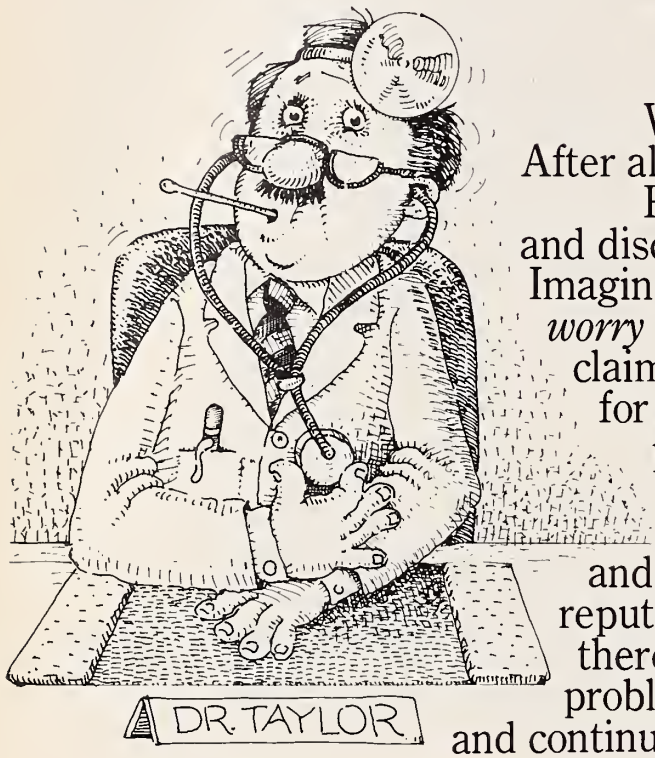
More than 80% of the newborns evaluated at the Medical College of Georgia for cyanotic congenital heart disease are referred from other institutions. In order to receive optimal care, these neonates require rapid diagnosis and immediate therapy of their life-threatening condition. Prior to transfer, the baby should be evaluated, and hypoglycemia and acidosis should be treated. Prostaglandin E_1 may be helpful in selected infants.

Medical and surgical management has undergone major changes in the last few years. The prompt recognition and appropriate referral of cyanotic infants should result in excellent long-term prognosis for the vast majority of these infants.[6]

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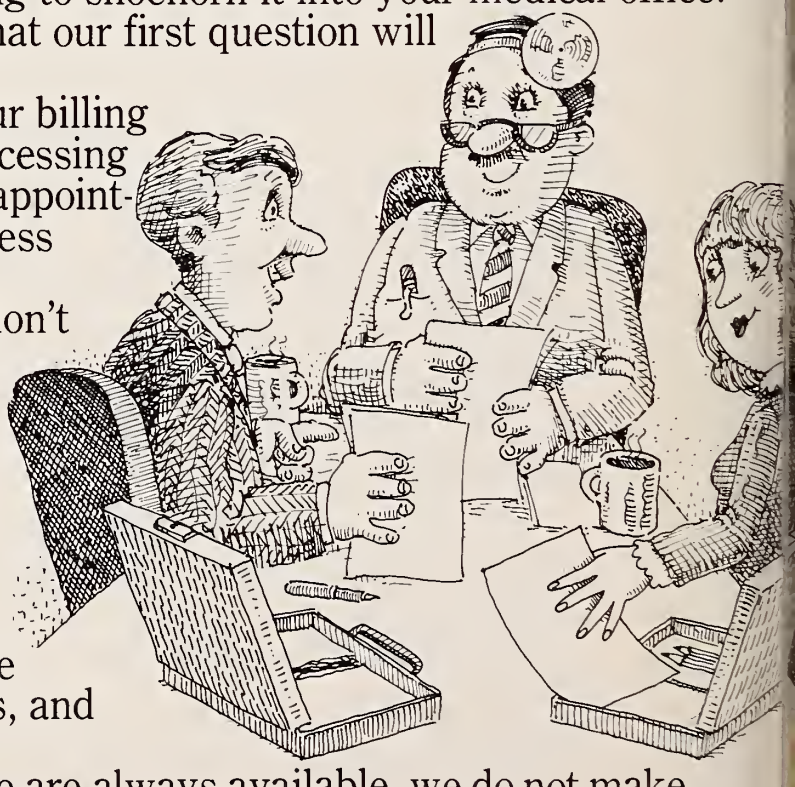
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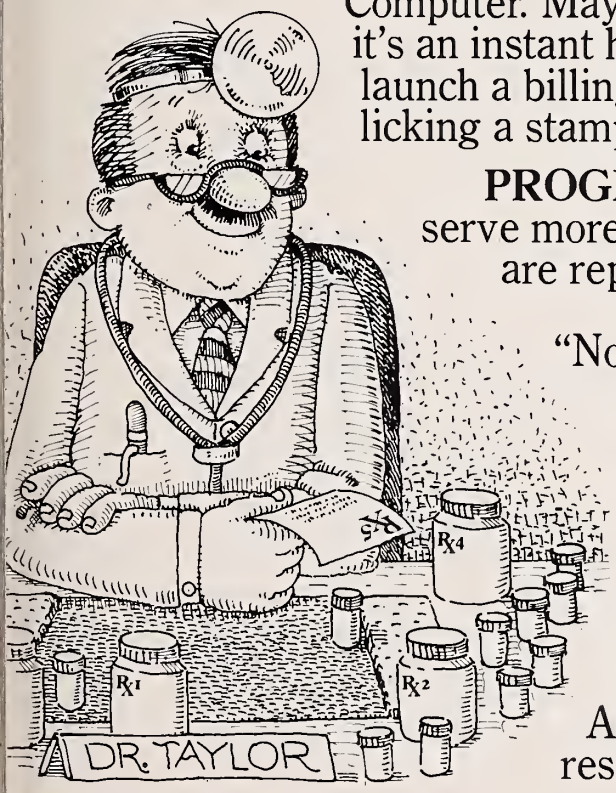


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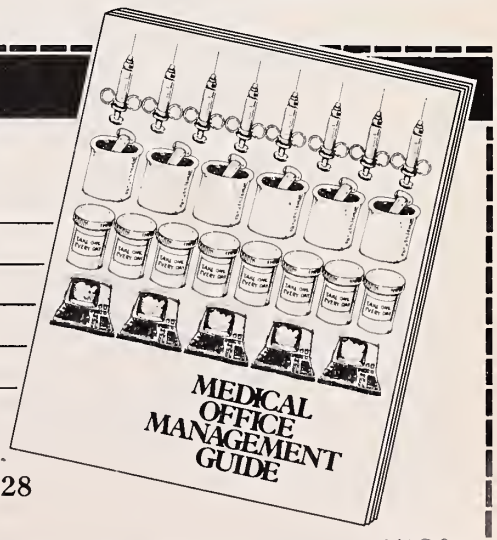
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MAG-9

president's letter



Auxiliary — It's More Than That!

The Auxiliary to the MAG was established in 1924. It would be interesting to know what prompted its beginning . . . whether to meet a local health need, for social reasons, or for whatever. Since its inception, no matter what the reason, the Auxiliary has become one of the most effective aids available to organized medicine.

Auxiliary activities and interests are many and varied. Auxilians staff local public health clinics, organize health fairs, conduct health screening programs, gather and disseminate information on health-related careers, work on drug abuse, child abuse, etc., raise money for local student loan programs for nurses and medical students, and participate in the AMA-ERF program. (Last year, the AMA Auxiliary contributed in excess of $2,000,000 to help support medical students in the United States.) All of these voluntary projects improve the quality of life in communities throughout the nation.

Do we appreciate them as much as they deserve? Have you considered recently what your spouse puts up with? She (or he) is not only married to you but also to your profession. Most doctors are compulsive individuals who are total slaves to their profession. They miss dinner engagements, vacations, and often are guilty of parental neglect. Many become deluded into thinking they are infallible and indispensable. "My patients need me, and no one else can help them as well as I can," we tell ourselves. Our spouses know differently, and they still put up with us. The leadership of the Medical Association is increasingly coming to recognize the Auxiliary as one of the most potent forces in medicine for public relations and legislative and community affairs. What a force this could become if all physicians' spouses get involved in this worthwhile activity!

Medicine faces incessant and constant pressures by those in the legislative arena who would change the very nature of our profession from a doctor-patient relationship to that of a public utility. The MAG Legislative Department wants and needs Auxiliary support and help in this area, in both our state and national capitals. Legislators have a hard time saying "no" to a woman.

As we face controversial issues in the future, the public will ultimately decide the course it wants us to take. The Auxiliary can play a vital role in getting medicine's story before the public. MAG's Public Relations Department is available to help their efforts which must begin in the local community.

Our spouse organization is called the Auxiliary, but I consider it to be more than that. Just as our spouses are our prime backers and supporters at home, we must continue to recognize the potential for their support in all our endeavors. It's time for the MAG to consider the MAG Auxiliary more as a partner. Outside the organization, Auxiliary members are more than our partners, they're our roommates! We love 'em!

S. William Clark

the association
the association
the association

NEW MEMBERS

Aitcheson, Carol T., MAA—ACT (N-1)—IM/RHU
35 Collier Rd., NW, Ste. 775, Atlanta 30309

Ajayi, Rex O., Dougherty—ACT—U
1009 N. Monroe St., Albany 31701

Almand, Marshall D., Newton-Rockdale—ACT (N-2)—IM
1309 Milstead Rd., Conyers 30207

Baldrich, David A., DeKalb—ACT (N-1)—IM/GE
487 Winn Way, Decatur 30030

Brown, Samuel E., Spalding—ACT—R
Griffin Spalding County Hospital, Griffin 30223

Davis, Donald M., MAA—ACT (N-1)—AN
Northside Hospital, Dept. of Anesthesiology, 1000 Johnson Ferry Rd., NE, Atlanta 30342

Egan, Robert F., MAA—ACT—IM
11050 Crabapple Rd., Ste. 105, Roswell 30075

Elkon, David, Bibb—ACT—R
770 Pine St., Ste. L-20, Macon 31201

Fehlenberg, Richard D., Bibb—ACT—FP
1550 College St., Macon 31201

Feinberg, Steven D., MAA—ACT—PM
11685 Alpharetta Hwy., Roswell 30076

Goforth, Gary A., Muscogee—Service—FP/AM
Aviation Medicine Clinic, Fort Benning 31905

Greenberg, Michael J., Gwinnett-Forsyth—ACT (N-2)—AN
Joan Glancy Hospital, 3215 McClure Bridge Rd., Duluth 30136

Haney, Steven T., MAA—ACT (N-1)—P
400 Colony Square, Ste. 1010, 1201 Peachtree St., NE, Atlanta 30361

Hatmaker, David L., C. W. Long—Service—FP
295 Westwood Dr., Athens 30606

Hudson, William M., Gwinnett-Forsyth—ACT (N-2)—CD
119 Scenic Hwy., Lawrenceville 30245

Katz, Stephen J., Bibb—ACT—GS
777 Hemlock St., Macon 31201

Mallsby, Gilbert O., Muscogee—ACT—DR/NR
717-20th St., Box 2787, Columbus 31994

Mason, Gayle L., MAA—I&R—IM/PUD
N. Fulton Medical Arts Center, Roswell 30076

McKinstry, Larry D., Meriwether-Harris-Talbot—ACT—PM
Roosevelt Institute, P.O. Box 1000, Warm Springs 31830

Mintz, Stephen M., Newton-Rockdale—ACT—ORS
1359 Milstead Rd., Ste. 103, Conyers 30208

Moore, Terrence J., Muscogee—Service—AN
Anesthesiology Service, Martin Army Community Hospital, Fort Benning 31905

Olson, Gary W., Whitfield-Murray—ACT (N-2)—IM/CD
1436 Broadrick Dr., Dalton 30720

Pennington, Charles R., Stephens-Rabun—ACT (N-2)—FP
Betty's Creek Rd., Box 444, Dillard 30537

Price, Thomas E., MAA—I&R—ORS
80 Butler St., Atlanta 30303

Roberts, Jerry M., Coweta—ACT (N-2)—PD
198 Hwy. 54 East, Peachtree City 30273

Salazar, John F., Douglas—ACT—IM/CD
8954 Hospital Way, Ste. 110-B, Douglasville 30134

Schienberg, Paul J., MAA—ACT—PUD
993 Johnson Ferry Rd., NE, Ste. D-210, Atlanta 30342

Stevens, Walter C., Gwinnett-Forsyth—ACT (N-1)—AN
Joan Glancy Hospital, 3215 McClure Bridge Rd., Duluth 30136

Trakhtengerts, Valentina, Washington—ACT (N-2)—NS/N
Sandersville 31082

White, Sandra L., MAA—ACT (N-2)—RHU/IM
P.O. Box 603, Avondale Estates 30002

Wilson, Lennard S., MAA—ACT (N-2)—IM/N
25 Prescott St., NE, Atlanta 30365

PERSONALS

Fifth District

Maurice J. Jurkiewicz, M.D., chief of the Division of Plastic and Reconstructive Surgery at Emory University School of Medicine, has been named the 1984 recipient of the Scientific Achievement Award presented periodically by the American Medical Association in recognition of outstanding work in medicine. Under Dr. Jurkiewicz's direction, Emory's plastic and reconstructive surgery division has become widely known for its work with musculocutaneous flaps for all types of reconstructive procedures and in particular, reconstruction of the breast.

Seventh District

Murray County Memorial Hospital announced the addition of 3 MAG physicians to the medical staff. They are: **John D. Richmond, M.D., John Poehlman, M.D.,** and **Gary Olson, M.D.**

Roy T. Farrow, M.D., a pediatrician from Dalton, was named Board Member of the Year by the American Lung Association of Georgia at its recent annual meeting in Columbus. Dr. Farrow has served a number of years on the Lung Association Board and was recognized for special service in helping to design the association's 3-year program of work. He was also recognized for his service to the smoking and health committee. In giving the award, Lung Association president-elect Nesbit Shearouse said, "Giving a tremendous amount of time and professional expertise, Dr. Farrow is a selfless, dedicated volunteer and his positive attitude reflects his sincere desire to further the purposes of the Lung Association.

Dewey Hammond, M.D., set up a new private practice in White. Dr. Hammond originally set up the practice under a grant program subsidized by the Appalachian Regional Commission. The grant was intended to give physicians incentive to practice in rural areas. He recently requested that the funding be stopped, and he has acquired Bartow County Primary Health Care (formerly Bartow Health Care) as a private practice. Dr. Hammond divides his time between his practice in Fairmount and his new practice in White.

Ninth District

Internist **George S. Kleris, M.D.,** has assumed practice in general medicine at the Coker-Andrews Clinic in Canton. Dr. Kleris was director of the Department of Infectious and Communicable Diseases with the Georgia Department of Human Resources in Atlanta from 1972 until April.

Tenth District

Paul S. Mote, M.D., an assistant professor of anesthesiology at the Medical College of Georgia, received an Outstanding Young Faculty Award during the recent recognition awards ceremony at MCG. Dr. Mote received the award in clinical sciences.

DEATHS

E. Garland Herndon, Jr.

E. Garland Herndon, Jr., M.D., senior vice president of Emory University, died July 19.



Dr. E. Garland Herndon, Jr.

Dr. Herndon joined the Emory faculty in 1958. He played a vital role in several Emory institutions, particularly in the establishment and growth of the Robert W. Woodruff Health Services Center. Dr. Herndon was a professor of medicine, program director of the Clinical Research Center of the School of Medicine, medical director of the Emory University Hospital, associate dean of the School of Medicine, acting dean and associate director of the Emory Clinic. He was appointed to his new role as senior vice president in September, 1983. At the time of his death, he was also an active partner of the Emory Clinic in internal medicine.

After completing his internship at North Carolina Baptist Hospital, Dr. Herndon began a decade of service in the United States Medical Corps. In 1980, he received the Emory Woodruff Award of Dedication. In 1981, he was honored with the establishment of the E. Garland Herndon, Jr., Chair of Internal Medicine at Emory. In 1983, he was presented the first distinguished medical achievement award of Emory University's Medical Alumni Association. Bowman Gray School of Medicine had earlier presented him with a distinguished alumnus award. Dr. Herndon was a Diplomate of the American Board of Internal Medicine and a Fellow of the American College of Physicians. He served as a consultant to the National Institutes of Health, the Army, and many medical and health care organizations. He also served on the boards of the Coca-Cola Company and Blue Cross.

Dr. Herndon is survived by his wife, three daughters, and one son.

Joseph Pacifici

Joseph Pacifici, M.D., 77, died July 11 in Savannah. He had practiced medicine there since 1937.

Dr. Pacifici graduated from Harvard University and the Royal University in Rome, Italy. He played a key role in

(Continued on p. 645)

Committee Activities . . .

Highlights — MAG Executive Committee Meeting, July 15, 1984

Public Relations Committee (Child Abuse Campaign): MAG's PR Department reported that the MAG and DHR entered into a partnership for the prevention of child abuse. A kick-off news conference is scheduled for August 27 at 11:00 AM, with Governor Joe Frank Harris attending as the state's representative and Dr. S. William Clark as MAG's representative. Governor Harris will sign a proclamation announcing the campaign and the MAG/DHR partnership. This campaign is being effected with assistance from the MAG Auxiliary and will use public service announcements, slide and tape shows for physicians, media tours, informational kits for MAG county medical societies, television and publication advertisements.

***Journal* Policy Guidelines for Regional Advertising:** At its May meeting, the Executive Committee (EC) requested the editor of the *Journal* to formulate guidelines for regional advertising. The editor reported the following criteria are used to measure the appropriateness or desirability of a product, institution, or service advertisement: (1) ethical; (2) legal; (3) moral; (4) in good taste; and (5) not injurious to one's health. It was pointed out that the editor, in cooperation with the Publications Committee, is the final arbiter of the application of these criteria to advertisements submitted for consideration for publication in the *Journal*. The EC adopted the above as MAG's policy for regional advertising.

MAG Newsletter: The 1984 MAG House of Delegates directed MAG to seek legislation to exempt physicians from liability in the case of failure of generic drugs. The June MAG Board of Directors referred this matter to the MAG Committee on Legislation and directed that an article be published in the MAG Newsletter. The editor of the Newsletter requested direction from the EC before publishing material relating to this matter (which was similar to a March 1977 Newsletter article). Following discussion, the EC voted to withhold publishing an article until such time as the Committee on Legislation finalized its report on this matter.

Risk Management Committee: The Chairman of the MAG Risk Management Committee gave a report to the EC concerning Workshop #2 now being developed by the Risk Management Committee. There was discussion regarding specialty societies participation in these workshops. The Chairman suggested the following for MAG in dealing with a charge for Risk Management workshops, re-couping monies, and developing specialty modules:

(1) MAG will be responsible for developing the four generic modules;

(2) MAG will be responsible for the instruction manual;

(3) MAG will distribute the entire workshop book to participants;

(4) MAG will officially co-sponsor and provide continuing medical education to the other co-sponsor;

(5) Specialty societies would develop their own three modules;

(6) Specialty society modules would be given to MAG for copyrighting;

(7) MAG would return a fixed amount to specialty societies for members of the society that attended the workshop.

Following discussion, the EC voted that the financial burden of this project would be the responsibility of the MAG and MAG Mutual Insurance Company with the stipulation that these programs should not be developed unless the specialty societies so desired them and would lend their co-sponsorship to the workshops.

AMA Resident Physician Section: Mary Lucchese, M.D., attended the AMA Resident Physician Section meeting in June on behalf of MAG. Dr. Lucchese submitted a rationale for establishing a Georgia Resident Physician Section (RPS) in conjunction with an MAG/AMA membership campaign. Following discussion, it was the unanimous concensus of the EC to invite Dr. Lucchese to work with the MAG Executive Director and staff in establishing a program and membership campaign for an MAG Resident Physician Section.

MAG Committee Appointments: The EC approved the following as members of MAG committees:

Daniel M. Feldman, M.D., Valdosta — Maternal & Infant Health;

William B. Jones, M.D., Gainesville — Medical Practice;

Susan Middleton, 4th-year, Emory — Committee on Medical Schools;

Brent Box, 2nd-year, Mercer — Committee on Medical Schools;

Ann Purcell (Mrs. Dent), Savannah — Health Education;

Thomas L. German, M.D., Savannah — Medical Aspects of Sports;

Robert W. Crow, M.D., Atlanta — Medical Aspects of Sports

Highlights of AMA Annual Meeting

The House of Delegates of the American Medical Association held its annual meeting in Chicago June 17-21. The House considered 182 resolutions and 73 reports. Following are highlights of that meeting.

Future Directions and Resource Needs

The House approved several recommendations of the Board of Trustees contained in a major report about AMA finances and membership.

- Of foremost interest to AMA members is that AMA dues will be maintained at current levels in 1985. The Reference Committee cautioned the House, however, that future AMA dues may have to be increased by $30 in 1986 and an additional $30 in 1987 in order to avoid major reductions in AMA programs and activities in those years.
- State medical associations will be allocated one extra delegate when 75 percent or more of the state society's members are also AMA members. Unified states (Illinois and Oklahoma) will be granted two additional delegates.

Diagnosis-Related Groups (DRGs)

Easily the dominant issue at the Annual Meeting was DRGs and their effect on the quality, cost, and availability of care. The House directed the Board to place a high priority on monitoring the system and report back at the 1984 Interim Meeting.

In other related actions, the House voted to:

- Continue the AMA's strong and concentrated efforts to seek elimination of the DRG attestation statement that requires physicians to certify primary and secondary diagnosis and procedures.
- Seek legislative and regulatory changes to ensure that differences in DRG-based payments to different categories of hospitals (rural and urban) are based on true differences in the costs of providing services by those hospitals rather than on arbitrary geographic criteria.
- Oppose the mandated algorithmic or cookbook/decision tree method of establishing a treatment regimen as cost effective under the Medicare payment system.
- Oppose the expansion of DRGs to physicians.
- Seek changes in the DRG system to provide adequate reimbursement for events arising during hospitalization that significantly add to a patient's requirements for care.

Automobile Safety

The House considered several resolutions related to the use of air bags and seat belts. The House supported:

- Mandatory installation of air bags in domestic and foreign cars.
- Legislation promoting the availability of seat belts in all motor vehicles, including buses and taxis, used to carry passengers.
- Mandatory seat best use laws.
- Mandatory child passenger restraint laws.

Tobacco and Health

Taking an aggressive anti-smoking stance the House approved several policies to position the Association in the forefront of anti-smoking groups. The House voted to:

- Urge Congress to strengthen warnings on cigarette packages to say that smoking causes cancer of the mouth, larynx, and lung; is a major cause of heart disease and emphysema; and is addictive; and may result in death.
- Study the safety and efficacy of nicotine chewing gum as an aid to smoking cessation.
- Ask the Surgeon General to place health hazard warnings on all snuff and chewing tobacco packages.
- Encourage physicians to schedule extra time to explain the health hazards of smoking to their patients.
- Urge hospitals, offices, and all other medical care facilities to declare themselves off-limits to smoking.
- Work to protect the health of non-smokers on airplanes.

Hospital Medical Staff Issues

The Hospital Medical Staff Section met for two days prior to the opening of the AMA House.

Over 700 representatives were registered from virtually every state. They considered about 60 resolutions and submitted 18 resolutions for consideration by the AMA House.

Enthusiasm among HMSS representatives remains high and participation in this policy-making process is expected to increase. The goal is to have every hospital send a representative to further enhance communication between the AMA and local hospital medical staffs.

The AMA House approved a number of resolutions related to the organization and operation of the medical staff. The House:

- Supported the medical staff's authority to approve or disapprove all amendments to medical staff bylaws.
- Supported the idea that hospital governing boards cannot unilaterally change medical staff bylaws.
- Asked the AMA to prepare and distribute a document on the legal status of medical staffs.
- Encouraged hospitals and medical staffs to make all medical staff rules available to physicians.
- Directed the AMA to oppose any regulation that would mandate voting privileges for non-physician members of the medical staff.
- Recommended that medical staffs develop bylaw provisions that affirm the binding effect of medical staff bylaws on the hospital governing board and the medical staff.

Professional Liability

On the last day of the meeting, the Board of Trustees submitted a report informing the House that a special task force will be established to study professional liability. The task force is charged with coordinating current AMA activities and focusing them on professional liability insurance.

AMA Executive Vice President, James H. Sammons, M.D., will chair the task force. Other members include AMA General Counsel, the Assistant Executive Vice

(Continued on p. 645)

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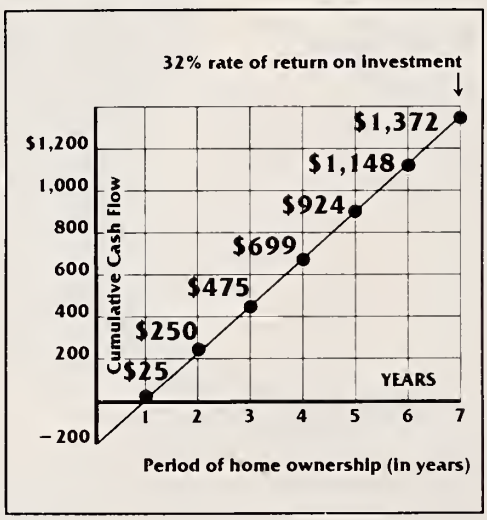
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Owning an energy efficient house can make you money. Conservation features can more than pay for themselves through reduced energy costs, giving you a handsome rate of return on your initial investment. And the money you save on energy is *tax-free*. The same holds true when you buy an energy efficient house. The graph (right) illustrates the potential return on investing an additional $200 down payment in a house with $1,000 worth of energy-saving features.



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AMA Report — Continued from p. 642

President, and two Deputy Executive Vice Presidents.

The Board will submit a report at the 1984 Interim Meeting.

Cognitive Services Reimbursement

The House considered five resolutions pertaining to reimbursement for cognitive services. The House approved a substitute resolution that asked the AMA to:

- Support the concept that third party payors should provide more equitable reimbursement for physicians' services which are solely cognitive in comparison with their procedural services.
- Take appropriate action to promote more equitable reimbursement for solely cognitive services with third party payors, business groups, and other professional associations.

IRS Physician Impersonation

The House received a late resolution pertaining to a recently announced IRS campaign to have IRS agents impersonate physicians and other professionals. The House asked the AMA to monitor the situation and report back at the 1984 Interim Meeting.

Conclusion

The prevailing theme at this meeting was that the AMA must increase its membership. In trying to keep dues increases to a minimum, the delegates, for the first time, are volunteering to recruit at least five new members. It's called the Peer-to-Peer program and you are invited to accept a similar obligation to enlarge the representative base of the AMA by asking your colleagues to join.

AMA House meetings provide a unique educational opportunity, and you are encouraged to attend and participate. Any member of the Association may present testimony at the Reference Committee hearings and, of course, corridor discussions on the issues provide ample opportunities to get your views across.

If you can't come to the meeting you can still be represented through your delegate. Let your delegation know your opinions. *You* can also prepare a resolution and request that it be submitted to the House.

Many, many AMA policies began with an individual physician who had a good idea and coaxed it through the democratic process.

(Submitted by C. Emory Bohler, M.D., of Brooklet, MAG's delegate to the AMA.)

A Word About Auxiliary Membership

Membership recruitment is one of the main objectives of the Auxiliary to the MAG this year. The state membership chairman, Mrs. Charles Thomas, of Athens, and her committee of area Vice-Presidents, Mrs. Thomas Marks, of Atlanta, Mrs. Robert Anderson, of Canton, Mrs. Carroll Tuten, of Brunswick, and Mrs. Jessee Hester, of Tifton, are spearheading this major effort to increase membership in the Auxiliary.

Never before has the need for members been so vital. This is an election year, and the need to make sure our candidates are friends to medicine is important. Auxiliary members will participate in legislative activities, letting their voices be heard on the issues which affect both health care and the private practice of medicine. The strength of the auxiliary is found in its members, and the more members they have, the greater their strength.

From August 20-30, a Join-a-Thon is planned for every Auxiliary in the state. Every eligible doctor's spouse who is a non-member will be contacted by telephone and invited to join the Auxiliary.

On October 10, each county Auxiliary will hold a Media/Legislative Recognition Day in which they will honor their local newspaper publishers, editors, T.V. and radio managers, and local legislators. Once again the hope is to attract potential Auxiliary members.

In the next few months, personal growth seminars will be held in 12 different locations in the state. At these seminars, Auxiliary members will be working to improve their communications skills. Featured experts will teach the dos and don'ts of lobbying. The schedule for these seminars is as follows: October 25, Thomasville; October 23, Athens; October 29, Dublin; November 6, Columbus; November 8, Cleveland; November 15, Americus; January 8, Atlanta; January 10, Augusta; January 15, Statesboro; January 17, Tifton; January 31, Rome; February 7, Waycross.

Physicians need to encourage their spouses to attend the seminar nearest them. It will be a rewarding experience.

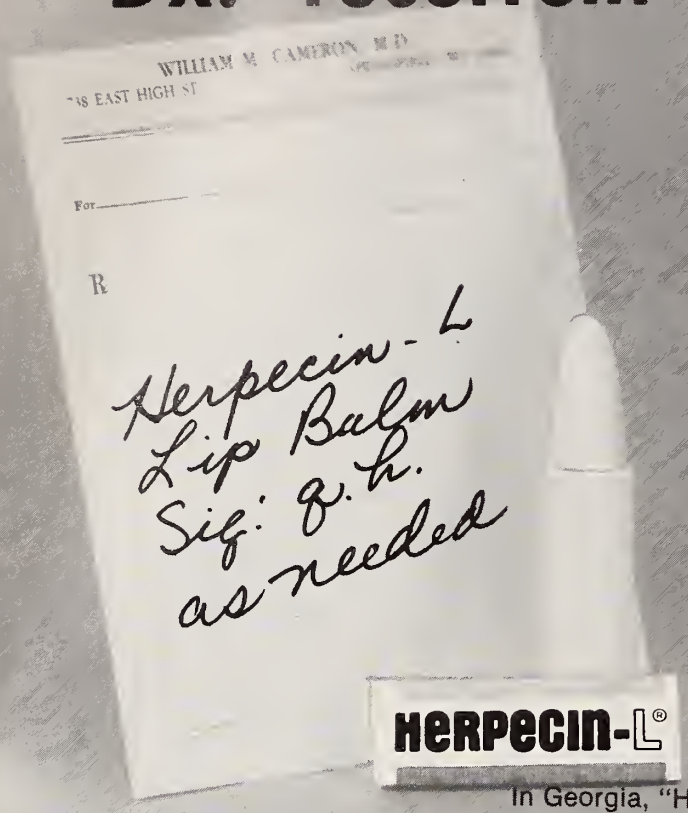
Doctors, ask your spouses to support your profession by joining the Auxiliary to the Medical Association of Georgia and the Auxiliary to the American Medical Association. Together we can "move mountains" for the sake of better health in our country.

Deaths — Continued from p. 640

promoting construction of Memorial Medical Center in the 1950s. He later served as chairman of the Chatham County Hospital Authority. Dr. Pacifici was the first recipient of the Cirincione Humanitarian Award, which was established to honor Savannahians of Italian descent who have made outstanding contributions to the community.

Survivors include his wife, six daughters, two sons, three sisters, three brothers, and 14 grandchildren.

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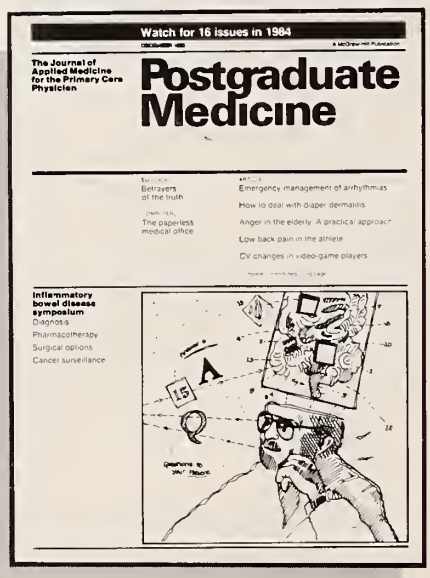
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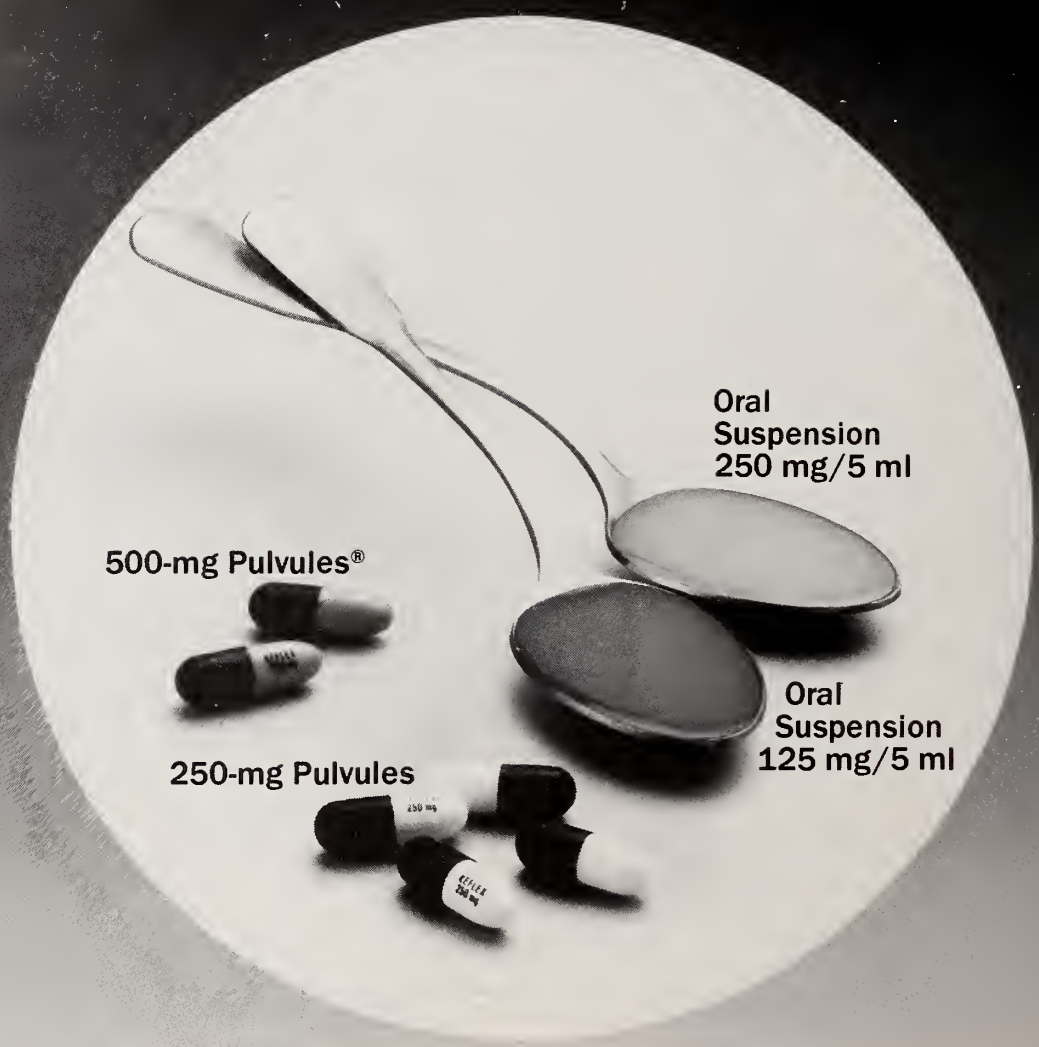
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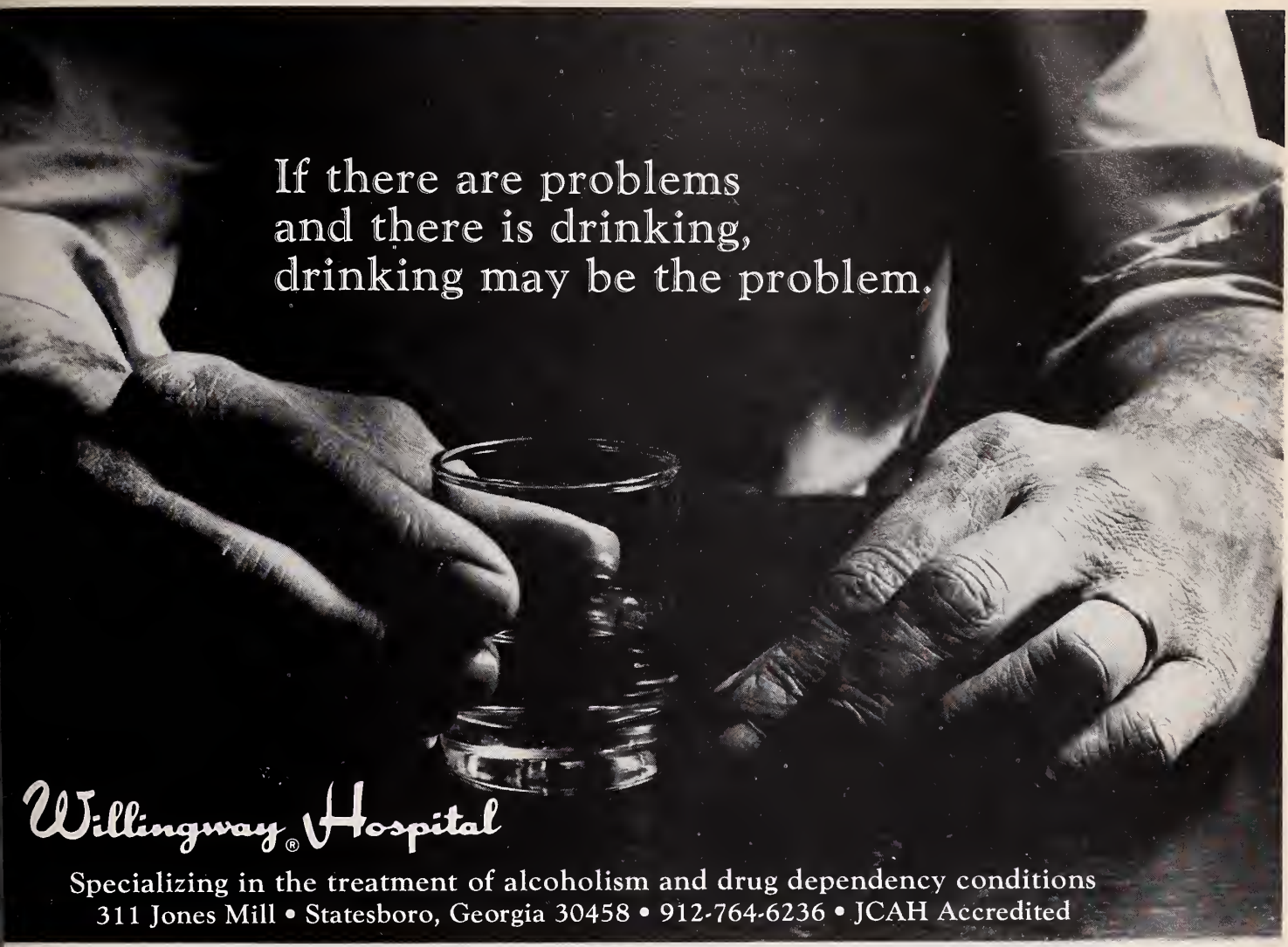
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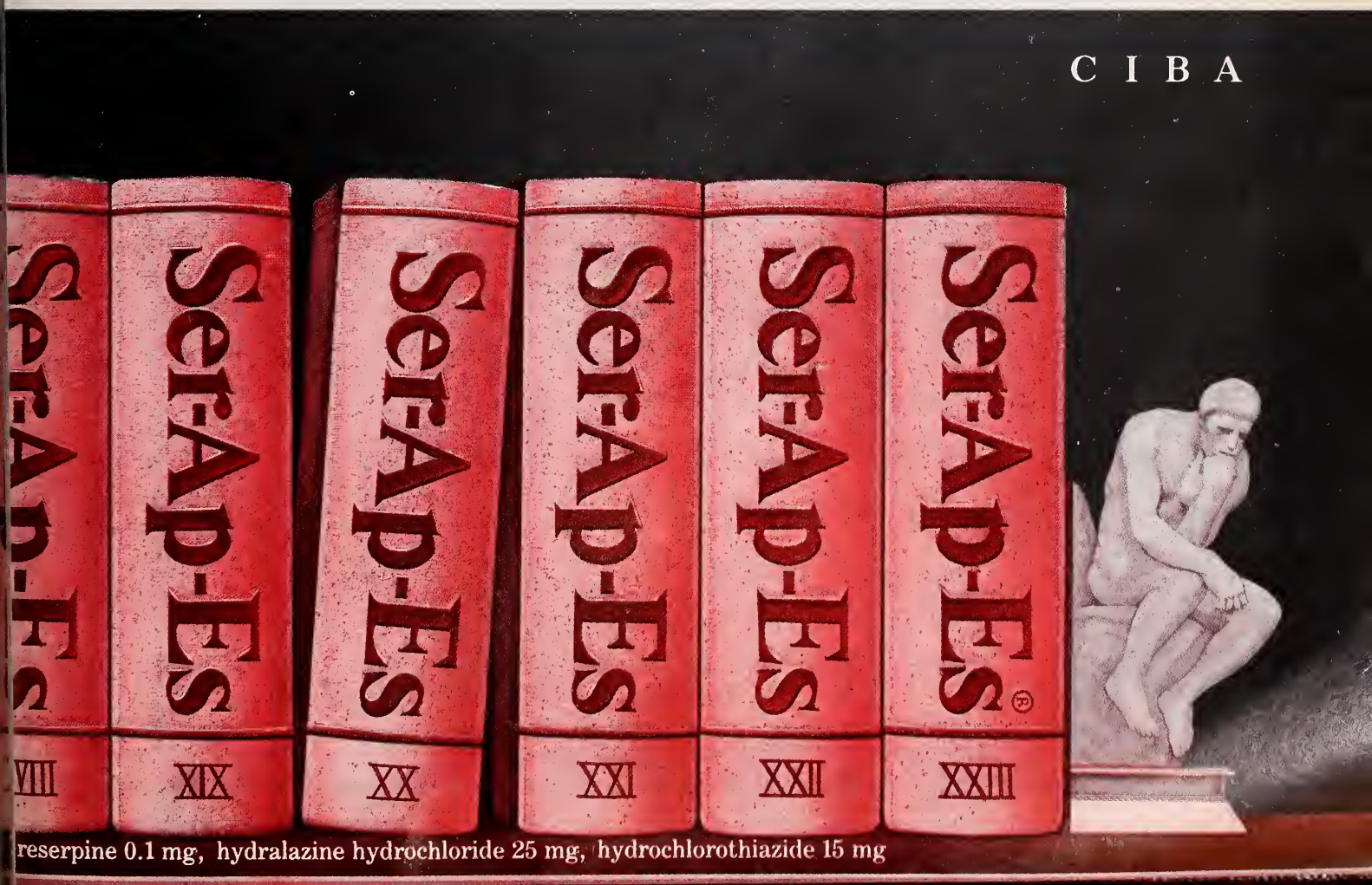
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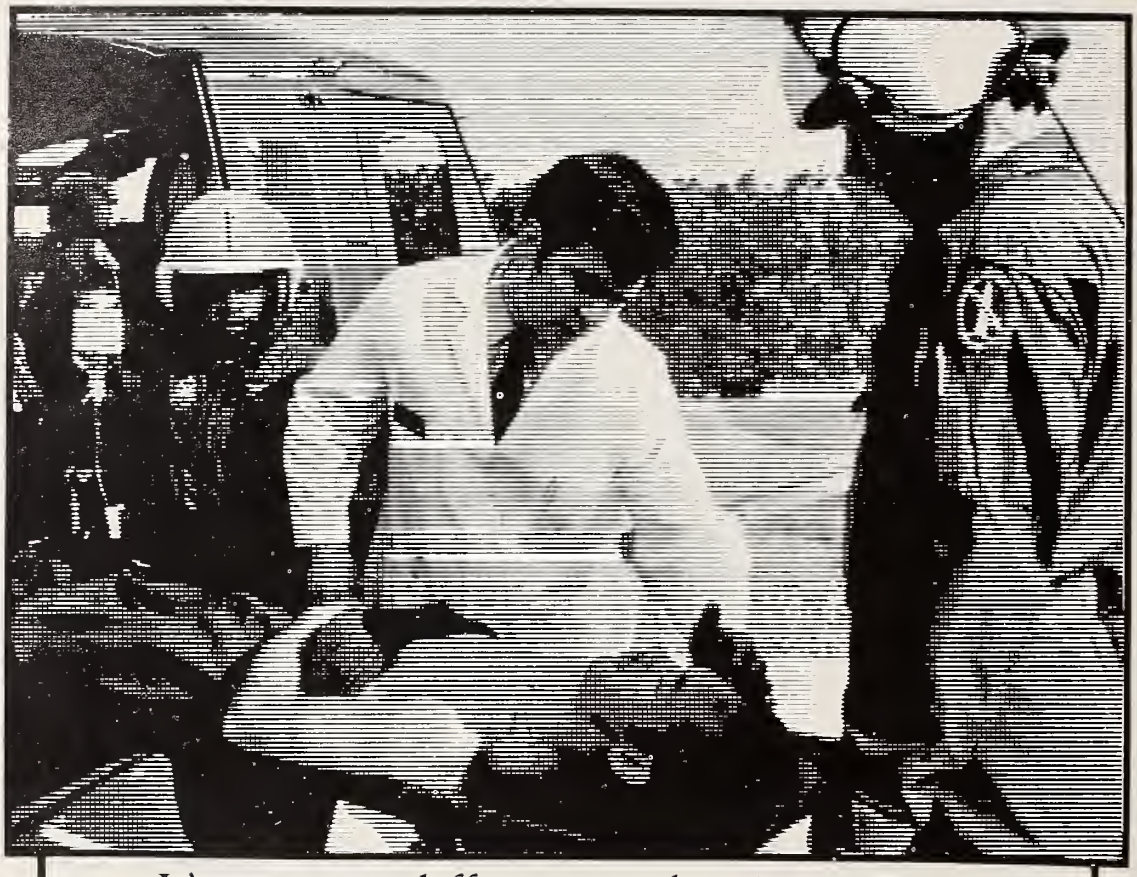
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> Soter NA, Wasserman SI, Austen KF. Cold urticaria release into circulation of histamine and eosinophil chemotactic factor of anaphylaxis during cold challenge. N Engl J Med 1976;294:687-90.

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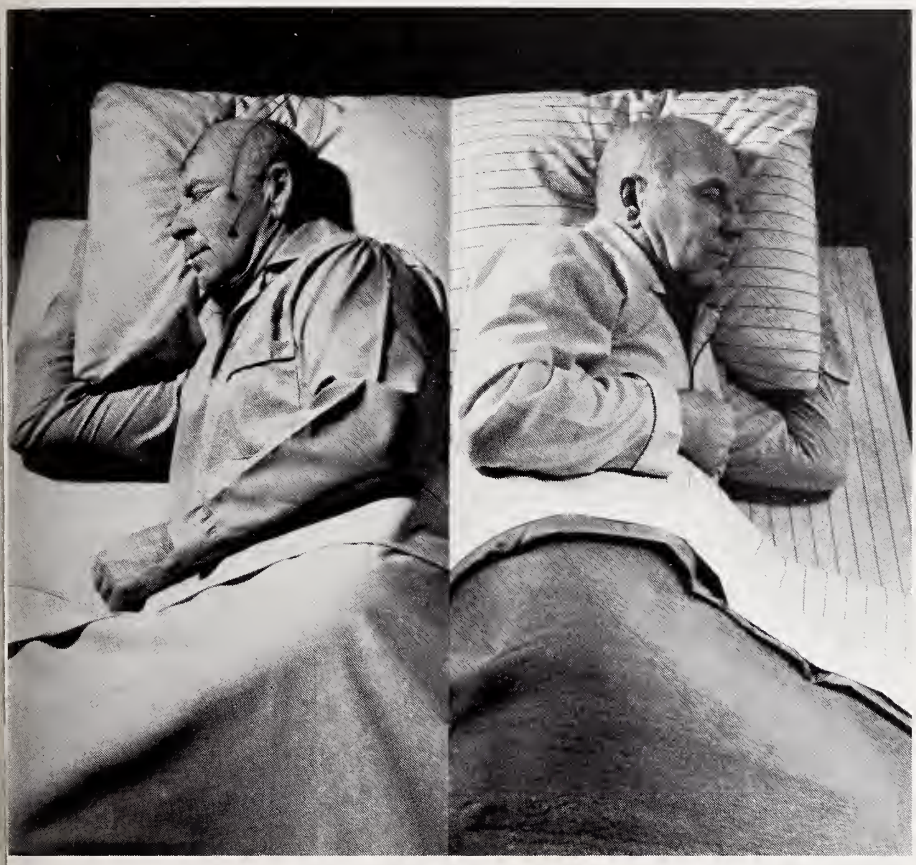
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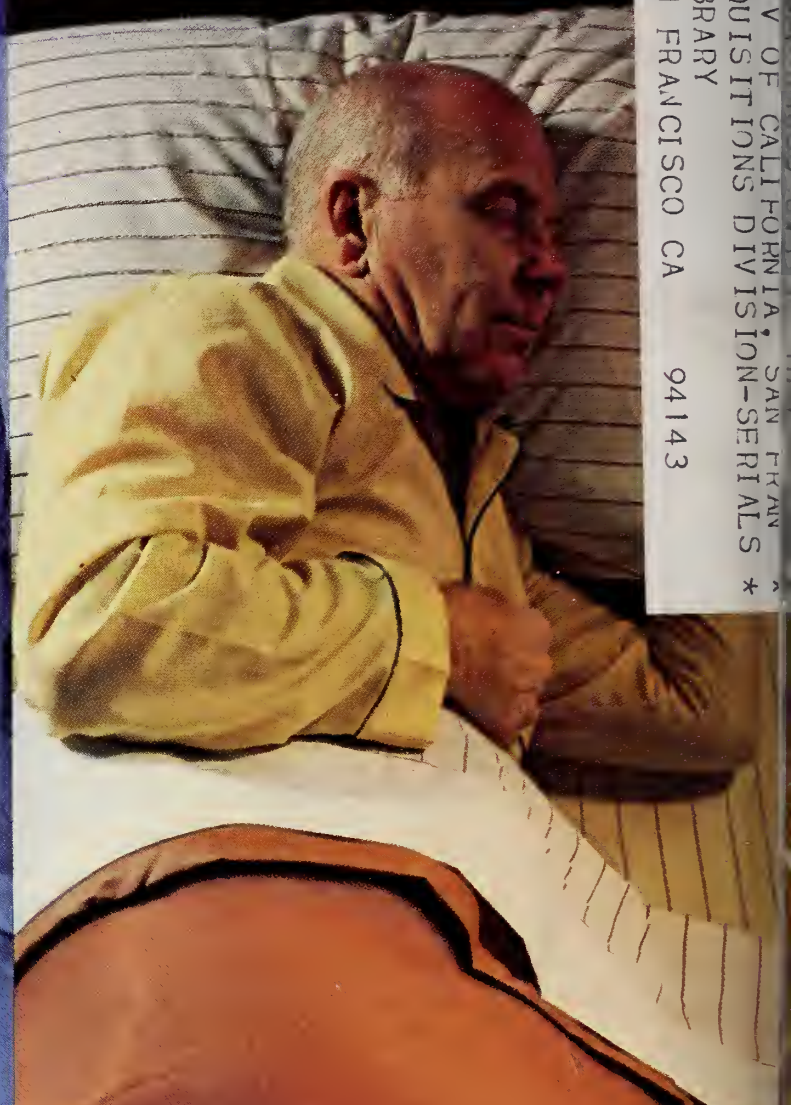
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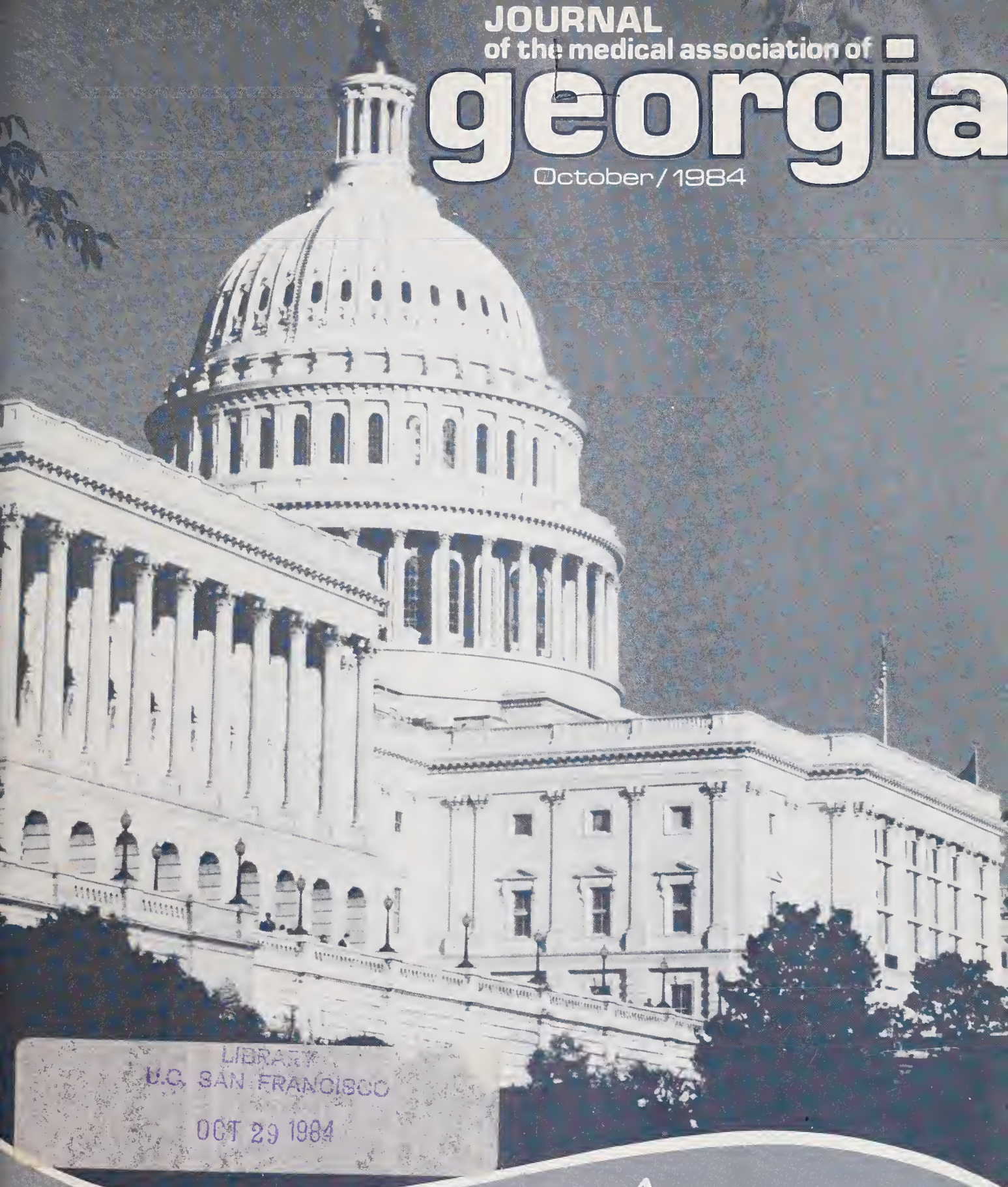
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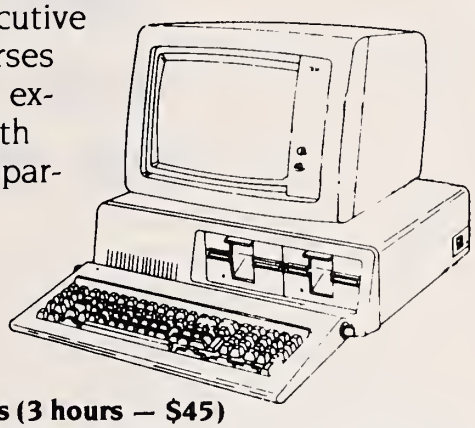
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JOURNAL
of the medical association of georgia

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VOLUME 73, NUMBER 10

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Established 1911. Owned and edited by the Medical Association of Georgia. Published monthly under the direction of the Board of Directors of the Association. Printed by The Ovid Bell Press, Inc., Fulton, Missouri.

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The subscription price per year for members of the Medical Association of Georgia is $7.50, included in the annual membership dues. The subscription price for nonmembers is $15.00 in the United States, Canada and Mexico, and $17.00 in other countries. Single copies are $2.

The *Journal of the Medical Association of Georgia* is published monthly at 938 Peachtree Street, N. E., Atlanta, GA 30309-3990. Second-class postage paid at Atlanta, Georgia, and at additional mailing offices. POSTMASTER: Send address changes to Medical Association of Georgia, 938 Peachtree Street, N. E., Atlanta, GA 30309-3990.

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Photograph by Lynwood Hall of Moultrie, Georgia.

MEDICAL MEETING CALENDAR

OCTOBER

18-21 — *Sea Island:* **Georgia Orthopaedic Society Annual Meeting.** Category 1 credit. Contact William C. Collins, M.D., Secy.-Treas., GOS, 993 Johnson Ferry Rd., NE, Ste. 100, Atlanta 30342. PH:404/255-4582.

21-24 — *Atlanta:* **Teaching Family Medicine in an Era of Competition.** Sponsored by the Family Medicine Educators in Georgia AAFP prescribed credit. Contact Georgia Academy of Family Physicians, 11 Corporate Square, Ste. 205, Atlanta 30329. PH:404/321-7445.

24-26 — *Atlanta:* **Skeletal Radiology.** Category 1 credit. Contact Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., NE, Atlanta 30322. PH:404/329-5695.

24 — *Columbus:* **Day of Endocrinology.** Category 1 and AAFP prescribed credit. Contact Judy Anderson, Int. Med. Found., P.O. Box 311, Columbus 31902-0311. PH:404/571-1454.

25 — *Atlanta:* **Health and Fitness: The Corporate View.** Contact Barb Christopherson, Health and Fitness, P.O. Box 52406, Cedar Rapids, Iowa 52404. PH:319/365-1663.

28-31 — *Helen:* **Psychiatric Institute on Group Behavior and Group Leadership.** Category 1 credit. Contact Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., NE, Ste. 110, Atlanta 30322. PH:404/329-5695.

29-31 — *Augusta:* **Neurosonography.** Category 1 credit. Contact Div. of Cont. Ed., MCG, Augusta 30912. PH:404/828-3967.

NOVEMBER

4-7 — *New Orleans, LA:* **Southern Medical Association 78th Annual Scientific Assembly.** Contact Southern Med. Assn., 2601 Highland Ave., Birmingham, AL 35201.

5-10 — *Atlanta:* **American Society of Cytology.** Contact ASC, 130 S. 9th St., Ste. 810, Philadelphia, PA 19107. PH:215/922-3880.

11-16 — *Atlanta:* **American Academy of Ophthalmology.** Contact AAO, P.O. Box 7424, 1833 Filmore St., San Francisco, CA 94120. PH:415/921-4700.

15-18 — *Atlanta:* **Georgia Academy of Family Physicians' Annual Meeting.** Category 1 and AAFP prescribed credit. Contact Camille L. Day, Exec. Vice-Pres., GAFP, 11 Corporate Square, Ste. 205, Atlanta 30329. PH:404/321-7445.

16-18 — *Atlanta:* **MAG Scientific Assembly.** Category 1 credit. Contact Stephen Davis, Dir. of Ed., MAG, 938 Peachtree St., N.E., Atlanta 30309. PH:404/876-7535 or 1-800-282-0224 (toll free in Ga.).

28-Dec. 2 — *Atlanta:* **Ninth Southeastern Conference on Alcohol and Drug Abuse.** Contact Barbara Turner, Charter Med. Corp., Addictive Disease Div., 5780 Peachtree-Dunwoody Rd., N.E., #170, Atlanta 30342.

DECEMBER

1-2 — *Atlanta:* **Regional Anesthesia: Surgery, Obstetrics, and Pain.** Category 1 credit. Contact Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., NE, Ste. 110, Atlanta 30322. PH:404/329-5695.

3-7 — *Atlanta:* **MKSAP VI Review Course.** Category 1 credit. Contact Registrar, Amer. Coll. of Phy., 4200 Pine St., Philadelphia, PA 19104. PH:800/523-1546.

6-9 — *Atlanta:* **From Head to Toes: A Practical Approach to Orthopaedics for the Primary Care Physician.** Category 1 credit. Contact Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., NE, Ste. 110, Atlanta 30322. PH:404/329-5695.

FEBRUARY

4-8 — *Puerto Vallarta, Mexico:* **Ninth Annual Conference on Pain.** Category 1 credit. Contact Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., NE, Ste. 110, Atlanta 30322. PH:404/329-5695.

6-10 — *Puerto Vallarta, Mexico:* **Scottish Rite 7th Annual Pediatric Postgraduate Course.** Category 1 credit. Contact Judson L. Hawk, Jr., MD, Dir. of Ped. Ed., Scottish Rite Children's Hosp., 1001 Johnson Ferry Rd., Atlanta 30363. PH:404/257-2040.

18-22 — *Park City, Utah:* **Third Annual Winter Urology Seminar.** Category 1 credit. Contact Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., NE, Ste. 110, Atlanta 30322. PH:404/329-5695.

18-23 — *Augusta:* **Family Practice Symposium.** Category 1 credit. Contact Div. of Cont. Ed., Med. Coll. of Ga., Augusta 30912. PH:404/828-3967.

MARCH

11-15 — *Park City, Utah:* **Orthopaedics Course.** Category 1 credit. Contact Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., NE, Ste. 110, Atlanta 30322. PH:404/329-5695.

18-22 — *Park City, Utah:* **Orthopaedics Course.** Category 1 credit. Contact Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., NE, Ste. 110, Atlanta 30322. PH:404/329-5695.

APRIL

11-13 — *Atlanta:* **Introduction Into Percutaneous Transluminal Angioplasty V.** Category 1 credit. Contact Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., NE, Ste. 110, Atlanta 30322. PH:404/329-5695.

14-18 — *Atlanta:* **Demonstrations in Percutaneous Transluminal Angioplasty XIII.** Category 1 credit. Contact Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., NE, Ste. 110, Atlanta 30322. PH:404/329-5695.

25-27 — **Practical Applications of Computers in Health Care: The Integration of Clinical and Administration Information.** Category 1 credit. Contact Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., NE, Ste. 110, Atlanta 30322. PH:404/329-5695.

28-May 1 — *Atlanta:* **Magnetic Resonance Imaging.** Category 1 credit. Contact Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., NE, Ste. 110, Atlanta 30322. PH:404/329-5695.

29-May 5 — *Augusta:* **Family Practice Symposium.** Category 1 credit. Contact Div. of Cont. Ed., MCG, Augusta 30912. PH:404/828-3967.

JUNE

14-16 — *Hilton Head Island, SC:* **Georgia Society of Dermatologists Annual Meeting.** Category 1 credit. Contact Gerald Chotiner, MD, 3250 Howell Mill Rd., Atlanta 30327. PH:404/352-1730.

AUGUST

19-23 — *Kiawah Island, SC:* **Summer Imaging.** Category 1 credit. Contact Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., NE, Ste. 110, Atlanta 30322. PH:404/329-5695.

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MAG's Child Abuse Prevention Campaign

MAG, in conjunction with the Georgia Department of Human Resources, kicked off the "It's OK To Tell" child abuse prevention campaign on Monday, August 27. The reception and news conference, held at the Academy of Medicine in Atlanta and featuring Governor Joe Frank Harris as the honored guest, was attended by over 300 people — among them legislators, judges, Auxiliary members, MAG members, DHR personnel, other medical personnel, members of the general public, and the media. All the major television stations in Atlanta, and various radio stations and newspapers around the state covered the event. The Governor had spoken about the campaign on Good Morning America earlier that day.



This exhibit on child abuse, featuring various components of the MAG/DHR sponsored "It's OK To Tell" campaign, was displayed at the Academy of Medicine during the news conference on August 27.



Dr. S. William Clark, Jr., Waycross, President of the MAG, discusses some last minute details relative to his opening remarks before the news conference with Ms. Sherry Waronker, MAG's Assistant Director of Communications.

Other featured speakers included S. William Clark, Jr., MD, of Waycross, President of MAG and emcee of the news conference; Mrs. Robley Smith (Ann) of Tifton, President of A-MAG; Commissioner James Ledbetter of DHR; and Ms. Kathryn Flanagan of the Clayton County Department of Family and Children Services. The reception following the news conference was hosted by the Auxiliary to the Medical Association of Atlanta.



Standing in front of the MAG Auxiliary's puppet "theater" which hosts a variety of plays informing children about such sensitive issues as child abuse are (right to left) Mrs. Milton B. Satcher (Ann), Atlanta, Past President of the MAG Auxiliary; Mrs. Robley D. Smith (Ann), Tifton, President of the MAG Auxiliary; Mrs. Philip R. Bartholomew, Atlanta, President of the Atlanta Auxiliary; and one other unidentified Auxiliary member.



Governor Joe Frank Harris listens to Dr. Bill Clark's opening remarks as the MAG and Georgia's Department of Human Resources (DHR) kick off a year-long campaign to increase the public's awareness of child abuse. Sitting to the Governor's right is DHR Commissioner James Ledbetter, and to the Governor's left, Mrs. Robley D. Smith (Ann) Tifton, President of the Auxiliary of the MAG.



DHR Commissioner James Ledbetter reported that 19,000 reports of child abuse and neglect, involving some 33,000 children, were received last year. He also noted that fewer than one child in a thousand gets cancer, while eight out of a thousand are found to be abused or neglected.



In his opening remarks at the news conference kicking off the child abuse campaign, Governor Joe Frank Harris expressed his concern for protecting our very youngest and most vulnerable citizens from the physical and psychologic ravages of child abuse.

There have been intense interest and various offers of assistance by community organizations, state organizations, and the media following the kickoff. Turner Outdoor Advertising has offered to donate 100 billboard spaces to help publicize the campaign. The response from the general public has also been enthusiastic.

This campaign, a year-long, joint venture by MAG and DHR, has the objective of increasing community awareness and reporting of child abuse. It is also our hope that through educating physicians and other professionals as to the law, they will realize that they are protected under law in reporting suspected child abuse. As respected leaders in the community, physicians are looked to for guidance in alleviating the horrible problem of child abuse. MAG's involvement in this campaign reinforces the caring, concerned role physicians always play in protecting the health and safety of children and families.

HCFA Officials Deny Rationing Under PROs

Federal officials in charge of Medicare's new peer review organization system have sought to diffuse charges that the system relies on state quotas that could lead to rationing of care for elderly and disabled beneficiaries.

Health Care Financing Administration officials defended their implementation of the PROs at a Senate Finance Health Subcommittee hearing. Subcommittee Chairman David Durenberger (R-MN), who sponsored the original PRO legislation, held the hearing in response to widespread criticisms stemming from the first PRO contracts.

The criticisms centered on admissions and quality objectives in the contracts that specified percentages and numbers of cases by which the PROs intended to reduce certain types of admissions, hospital complications and "avoidable deaths."

The major questions centered on how the goals were arrived at, whether they are achievable, and how strictly HCFA will hold the PROs to the objectives in their contracts.

Several of the witnesses — including representatives of the American Medical Association and the American Medical Peer Review Association urged that the PRO contracts be modified to specify that contracts could be renegotiated. Sen. Durenberger questioned HCFA's decision to seek actual reductions in admissions rather than simply trying to hold the line under the new diagnosis related group (DRG) payment system which critics say could increase hospital admissions.

HCFA Administrator Carolyne Davis insisted that the objectives should be viewed as targets not quotas. She told Durenberger that his legislation's requirement of performance-based contracts necessitated the development of specific numerical "milestones" against which to measure the PRO performance.

Davis also contended that although the PRO bidders worked within HCFA parameters, the bidders set their own goals, surprising the HCFA officials in some instances with the "ambitiousness" of the proposals. She claimed the objectives "are achievable" and defended the decision to call on PROs to reduce rather than simply hold down admissions.

Davis, who also pledged to work with hospital and medical groups in implementing the program, met with the AMA, AMPRA and the American Hospital Association August 21.

Physicians to be Recruited for Research

The National Institutes of Health and the Howard Hughes Medical Institute in August launched a new multi-million dollar program to boost biomedical research and increase the flow of new physicians into research careers.

The program will choose 30 medical students a year for six months to a year of research under the guidance of NIH scientists. Recruitment will begin this fall, with the first group of students entering the program in the fall of 1985.

"It is expected that this early exposure to the excitement and intellectual challenge of research — after the second year of medical school — will encourage more medical students to undertake careers in biomedical research," said Donald S. Fredrickson, MD, president of the Hughes Medical Institute (HHMI).

There is a serious shortage of physicians in research, say authorities. The consequence, they fear, may be a breakdown in the transfer of knowledge from the lab to the bedside.

HHMI, one of the largest private medical research organizations in the world, will support the program at a cost of $10.5 million for the first five years, which includes stipends, travel and support for the students, and building renovation and construction. NIH and HHMI will cooperate on selection of students, counseling, teaching, and interaction with students when they return to their home institutions.

AMA Will Sue Over Medicare Amendments

The American Medical Association Board of Trustees on August 28 announced the Association's intention to file suit challenging the constitutionality of the Medicare amendments passed with the Deficit Reduction Act of 1984 containing the reimbursement freeze under Medicare and provisions establishing "participating" and "nonparticipating" classes of physicians.

Announced by AMA Board Chairman John J. Coury, Jr., MD, the statement said that the AMA believes that the amendments will deny Medicare beneficiaries the ability to select the physician from whom they will receive care. In addition, the legislation freezes non-participating physicians' fees to Medicare patients until October 1, 1985. This singles out non-participating physicians, alone among all segments of our society, by forbiding them from freely entering into contractual agreements with patients.

The Act authorizes penalties against non-participating physicians (those physicians who do not agree to accept assignment in 100% of their Medicare cases) who raise their charges.

Finally, the provisions that mandate restrictive fee schedules for clinical laboratories will deprive Medicare beneficiaries and others of complete medical services by promoting the reduction of those services, particularly in small and rural communities.

The AMA is concerned that this legislation will seriously jeopardize the availability, access and complete delivery of medical services to the American people.

Tougher Labels For Two Anti-Inflammatories

Facing growing criticism of the safety of two anti-inflammatory drugs, the Department of Health and Human Services (HHS) has decided to keep the drugs on the market, but toughen up their labeling.

The drugs are overprescribed, not uniquely beneficial for any illness, and are too often administered for acute conditions such as tennis elbow or bursitis, HHS Secretary Margaret Heckler announced. She fell short of recommending withdrawal, however. The evidence does not indicate that the drugs pose an imminent hazard to public health, or that their approval applications should be suspended, she said.

The drugs — phenylbutazone and oxyphenbutazone, marketed since 1952 and 1961 under the trade names Butazolidin and Tandearil, respectively — face declining popularity, as safer alternatives have become available.

The public interest organization Health Research Group recently petitioned HHS to pull the drugs off the market, saying they have caused more than 10,000 deaths among the 135 million people who use them worldwide. Several other countries — including Britain, Sweden, Norway and Israel — have removed the drugs from the market or restricted their use.

Secretary Heckler rejected the HRG petition, but proposed the following changes:

* the medicines should be available for chronic arthritis victims in whom the risk of fatal blood disorders is reasonably related to the benefits.
* the labeling should be tightened to emphasize to doctors that they should not prescribe the drugs for acute, self-limiting conditions.

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References:

1. Strauss WE, McIntyre KM, Parisi AF, et al: Safety and efficacy of diltiazem hydrochloride for the treatment of stable angina pectoris: Report of a cooperative clinical trial. Am J Cardiol 49:560-566, 1982.
2. Pool PE, Seagren SC, Bonanno JA, et al: The treatment of exercise-inducible chronic stable angina with diltiazem: Effect on treadmill exercise. Chest 78 (July suppl):234-238, 1980.

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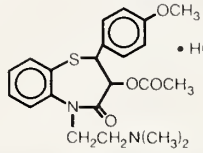
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The therapeutic benefits achieved with CARDIZEM are believed to be related to its ability to inhibit the influx of calcium ions during membrane depolarization of cardiac and vascular smooth muscle.

Mechanisms of Action. Although precise mechanisms of its antianginal actions are still being delineated, CARDIZEM is believed to act in the following ways:

1. Angina Due to Coronary Artery Spasm: CARDIZEM has been shown to be a potent dilator of coronary arteries both epicardial and subendocardial. Spontaneous and ergonovine-induced coronary artery spasm are inhibited by CARDIZEM.
2. Exertional Angina: CARDIZEM has been shown to produce increases in exercise tolerance, probably due to its ability to reduce myocardial oxygen demand. This is accomplished via reductions in heart rate and systemic blood pressure at submaximal and maximal exercise work loads.

In animal models, diltiazem interferes with the slow inward (depolarizing) current in excitable tissue. It causes excitation-contraction uncoupling in various myocardial tissues without changes in the configuration of the action potential. Diltiazem produces relaxation of coronary vascular smooth muscle and dilation of both large and small coronary arteries at drug levels which cause little or no negative inotropic effect. The resultant increases in coronary blood flow (epicardial and subendocardial) occur in ischemic and nonischemic models and are accompanied by dose-dependent decreases in systemic blood pressure and decreases in peripheral resistance.

Hemodynamic and Electrophysiologic Effects. Like other calcium antagonists, diltiazem decreases sinoatrial and atrioventricular conduction in isolated tissues and has a negative inotropic effect in isolated preparations. In the intact animal, prolongation of the AH interval can be seen at higher doses.

In man, diltiazem prevents spontaneous and ergonovine-provoked coronary artery spasm. It causes a decrease in peripheral vascular resistance and a modest fall in blood pressure and, in exercise tolerance studies in patients with ischemic heart disease, reduces the heart rate-blood pressure product for any given work load. Studies to date, primarily in patients with good ventricular function, have not revealed evidence of a negative inotropic effect; cardiac output, ejection fraction, and left ventricular end diastolic pressure have not been affected. There are as yet few data on the interaction of diltiazem and beta-blockers. Resting heart rate is usually unchanged or slightly reduced by diltiazem.

Intravenous diltiazem in doses of 20 mg prolongs AH conduction time and AV node functional and effective refractory periods approximately 20%. In a study involving single oral doses of 300 mg of CARDIZEM in six normal volunteers, the average maximum PR prolongation was 14% with no instances of greater than first-degree AV block. Diltiazem-associated prolongation of the AH interval is not more pronounced in patients with first-degree heart block. In patients with sick sinus syndrome, diltiazem significantly prolongs sinus cycle length (up to 50% in some cases).

Chronic oral administration of CARDIZEM in doses of up to 240 mg/day has resulted in small increases in PR interval, but has not usually produced abnormal prolongation. There were, however, three instances of second-degree AV block and one instance of third-degree AV block in a group of 959 chronically treated patients.

Pharmacokinetics and Metabolism. Diltiazem is absorbed from the tablet formulation to about 80% of a reference capsule and is subject to an extensive first-pass effect, giving an absolute bioavailability (compared to intravenous dosing) of about 40%. CARDIZEM undergoes extensive hepatic metabolism in which 2% to 4% of the unchanged drug appears in the urine. In vitro binding studies show CARDIZEM is 70% to 80% bound to plasma proteins. Competitive ligand binding studies have also shown CARDIZEM binding is not altered by therapeutic concentrations of digoxin, hydrochlorothiazide, phenylbutazone, propranolol, salicylic acid, or warfarin. Single oral doses of 30 to 120 mg of CARDIZEM result in detectable plasma levels within 30 to 60 minutes and peak plasma levels two to three hours after drug administration. The plasma elimination half-life following single or multiple drug administration is approximately 3.5 hours. Desacetyl diltiazem is also present in the plasma at levels of 10% to 20% of the parent drug and is 25% to 50% as potent a coronary vasodilator as diltiazem. Therapeutic blood levels of CARDIZEM appear to be in the range of 50 to 200 ng/ml. There is a departure from dose-linearity when single doses above 60 mg are given; a 120-mg dose gave blood levels three times that of the 60-mg dose. There is no information about the effect of renal or hepatic impairment on excretion or metabolism of diltiazem.

INDICATIONS AND USAGE

1. **Angina Pectoris Due to Coronary Artery Spasm.** CARDIZEM is indicated in the treatment of angina pectoris due to coronary artery spasm. CARDIZEM has been shown effective in the treatment of spontaneous coronary artery spasm presenting as Prinzmetal's variant angina (resting angina with ST-segment elevation occurring during attacks).
2. **Chronic Stable Angina (Classic Effort-Associated Angina).** CARDIZEM is indicated in the management of chronic stable angina. CARDIZEM has been effective in controlled trials in reducing angina frequency and increasing exercise tolerance.

There are no controlled studies of the effectiveness of the concomitant use of diltiazem and beta-blockers or of the safety of this combination in patients with impaired ventricular function or conduction abnormalities.

CONTRAINDICATIONS

CARDIZEM is contraindicated in (1) patients with sick sinus syndrome except in the presence of a functioning ventricular pacemaker, (2) patients with second- or third-degree AV block except in the presence of a functioning ventricular pacemaker, and (3) patients with hypotension (less than 90 mm Hg systolic).

WARNINGS

1. **Cardiac Conduction.** CARDIZEM prolongs AV node refractory periods without significantly prolonging sinus node recovery time, except in patients with sick sinus syndrome. This effect may rarely result in abnormally slow heart rates (particularly in patients with sick sinus syndrome) or second- or third-degree AV block (six of 1243 patients for 0.48%). Concomitant use of diltiazem with beta-blockers or digitalis may result in additive effects on cardiac conduction. A patient with Prinzmetal's angina developed periods of asystole (2 to 5 seconds) after a single dose of 60 mg of diltiazem.
2. **Congestive Heart Failure.** Although diltiazem has a negative inotropic effect in isolated animal tissue preparations, hemodynamic studies in humans with normal ventricular function have not shown a reduction in cardiac index nor consistent negative effects on contractility (dp/dt). Experience with the use of CARDIZEM alone or in combination with beta-blockers in patients with impaired ventricular function is very limited. Caution should be exercised when using the drug in such patients.
3. **Hypotension.** Decreases in blood pressure associated with CARDIZEM therapy may occasionally result in symptomatic hypotension.
4. **Acute Hepatic Injury.** In rare instances, patients receiving CARDIZEM have exhibited reversible acute hepatic injury as evidenced by moderate to extreme elevations of liver enzymes. (See PRECAUTIONS and AOVERSE REACTIONS.)

PRECAUTIONS

General. CARDIZEM (diltiazem hydrochloride) is extensively metabolized by the liver and excreted by the kidneys and in bile. As with any new drug given over prolonged periods, laboratory parameters should be monitored at regular intervals. The drug should be used with caution in patients with impaired renal or hepatic function. In subacute and chronic dog and rat studies designed to produce toxicity, high doses of diltiazem were associated with hepatic damage. In special subacute hepatic studies, oral doses of 125 mg/kg and higher in rats were associated with histological changes in the liver which were reversible when the drug was discontinued. In dogs, doses of 20 mg/kg were also associated with hepatic changes; however, these changes were reversible with continued dosing.

Drug Interaction. Pharmacologic studies indicate that there may be additive effects in prolonging AV conduction when using beta-blockers or digitalis concomitantly with CARDIZEM. (See WARNINGS).

Controlled and uncontrolled domestic studies suggest that concomitant use of CARDIZEM and beta-blockers or digitalis is usually well tolerated. Available data are not sufficient, however, to predict the effects of concomitant treatment, particularly in patients with left ventricular dysfunction or cardiac conduction abnormalities. In healthy volunteers, diltiazem has been shown to increase serum digoxin levels up to 20%.

Carcinogenesis, Mutagenesis, Impairment of Fertility. A 24-month study in rats and a 21-month study in mice showed no evidence of carcinogenicity. There was also no mutagenic response in in vitro bacterial tests. No intrinsic effect on fertility was observed in rats.

Pregnancy. Category C. Reproduction studies have been conducted in mice, rats, and rabbits. Administration of doses ranging from five to ten times greater (on a mg/kg basis) than the daily recommended therapeutic dose has resulted in embryo and fetal lethality. These doses, in some studies, have been reported to cause skeletal abnormalities. In the perinatal/postnatal studies, there was some reduction in early individual pup weights and survival rates. There was an increased incidence of stillbirths at doses of 20 times the human dose or greater.

There are no well-controlled studies in pregnant women; therefore, use CARDIZEM in pregnant women only if the potential benefit justifies the potential risk to the fetus.

Nursing Mothers. It is not known whether this drug is excreted in human milk. Because many drugs are excreted in human milk, exercise caution when CARDIZEM is administered to a nursing woman if the drug's benefits are thought to outweigh its potential risks in this situation.

Pediatric Use. Safety and effectiveness in children have not been established.

ADVERSE REACTIONS

Serious adverse reactions have been rare in studies carried out to date, but it should be recognized that patients with impaired ventricular function and cardiac conduction abnormalities have usually been excluded.

In domestic placebo-controlled trials, the incidence of adverse reactions reported during CARDIZEM therapy was not greater than that reported during placebo therapy.

The following represent occurrences observed in clinical studies which can be at least reasonably associated with the pharmacology of calcium influx inhibition. In many cases, the relationship to CARDIZEM has not been established. The most common occurrences, as well as their frequency of presentation, are: edema (2.4%), headache (2.1%), nausea (1.9%), dizziness (1.5%), rash (1.3%), asthenia (1.2%), AV block (1.1%). In addition, the following events were reported infrequently (less than 1%) with the order of presentation corresponding to the relative frequency of occurrence.

Cardiovascular:	Flushing, arrhythmia, hypotension, bradycardia, palpitations, congestive heart failure, syncope.
Nervous System:	Paresthesia, nervousness, somnolence, tremor, insomnia, hallucinations, and amnesia.
Gastrointestinal:	Constipation, dyspepsia, diarrhea, vomiting, mild elevations of alkaline phosphatase, SGOT, SGPT, and LDH.
Dermatologic:	Pruritus, petechiae, urticaria, photosensitivity.
Other:	Polyuria, nocturia.

The following additional experiences have been noted:

A patient with Prinzmetal's angina experiencing episodes of vasospastic angina developed periods of transient asymptomatic asystole approximately five hours after receiving a single 60-mg dose of CARDIZEM.

The following postmarketing events have been reported infrequently in patients receiving CARDIZEM: erythema multiforme; leukopenia; and extreme elevations of alkaline phosphatase, SGOT, SGPT, LDH, and CPK. However, a definitive cause and effect between these events and CAROIZEM therapy is yet to be established.

OVERDOSAGE OR EXAGGERATED RESPONSE

Overdosage experience with oral diltiazem has been limited. Single oral doses of 300 mg of CARDIZEM have been well tolerated by healthy volunteers. In the event of overdosage or exaggerated response, appropriate supportive measures should be employed in addition to gastric lavage. The following measures may be considered:

Bradycardia	Administer atropine (0.60 to 1.0 mg). If there is no response to vagal blockade, administer isoproterenol cautiously.
High-Degree AV Block	Treat as for bradycardia above. Fixed high-degree AV block should be treated with cardiac pacing.
Cardiac Failure	Administer inotropic agents (isoproterenol, dopamine, or dobutamine) and diuretics.
Hypotension	Vasopressors (eg, dopamine or levarterenol bitartrate).

Actual treatment and dosage should depend on the severity of the clinical situation and the judgment and experience of the treating physician.

The oral LD_{50}'s in mice and rats range from 415 to 740 mg/kg and from 560 to 810 mg/kg, respectively. The intravenous LD_{50}'s in these species were 60 and 38 mg/kg, respectively. The oral LD_{50} in dogs is considered to be in excess of 50 mg/kg, while lethality was seen in monkeys at 360 mg/kg. The toxic dose in man is not known, but blood levels in excess of 800 ng/ml have not been associated with toxicity.

DOSAGE AND ADMINISTRATION

Exertional Angina Pectoris Due to Atherosclerotic Coronary Artery Disease or Angina Pectoris at Rest Due to Coronary Artery Spasm. Dosage must be adjusted to each patient's needs. Starting with 30 mg four times daily, before meals and at bedtime, dosage should be increased gradually (given in divided doses three or four times daily) at one- to two-day intervals until optimum response is obtained. Although individual patients may respond to any dosage level, the average optimum dosage range appears to be 180 to 240 mg/day. There are no available data concerning dosage requirements in patients with impaired renal or hepatic function. If the drug must be used in such patients, titration should be carried out with particular caution.

Concomitant Use With Other Antianginal Agents:

1. **Sublingual NTG** may be taken as required to abort acute anginal attacks during CARDIZEM therapy.
2. **Prophylactic Nitrate Therapy**—CARDIZEM may be safely coadministered with short- and long-acting nitrates, but there have been no controlled studies to evaluate the antianginal effectiveness of this combination.
3. **Beta-blockers.** (See WARNINGS and PRECAUTIONS.)

HOW SUPPLIED

Cardizem 30-mg tablets are supplied in bottles of 100 (NDC 0088-1771-47) and in Unit Dose Identification Paks of 100 (NDC 0088-1771-49). Each green tablet is engraved with MARION on one side and 1771 engraved on the other. CAROIZEM 60-mg scored tablets are supplied in bottles of 100 (NDC 0088-1772-47) and in Unit Dose Identification Paks of 100 (NDC 0088-1772-49). Each yellow tablet is engraved with MARION on one side and 1772 on the other.

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Health Care Issues On The Hill: Working Toward Solutions

J. ROY ROWLAND, M.D., *Washington, D.C.**

A Political Melodrama

A MAJOR POLITICAL MELODRAMA is developing over health issues in Washington, and the outcome is likely to eventually shape a new relationship between the medical profession and the federal government. It is a relationship that may, or may not, be marked by excessive government regulation and control.

This process of change was already underway when I took the oath as Georgia's Eighth District Congressman on January 3, 1983, after putting aside my practice as a family physician for the first time in 28 years. I felt it was important for physicians to be involved in public affairs then, and I am now more convinced of that need than ever. Members of the medical profession perhaps have their greatest challenge before them today.

The membership of the Medical Association of Georgia and the American Medical Association can lead the way in developing a national strategy for health care that provides the best government has to offer without abandoning basic free market values. Physicians, after all, have the experience and knowledge to determine what kind of delivery system works best for medicine.

Involved in this unfolding "melodrama" are two broad areas of concern. One area is represented by the ethical and economic questions that have emerged from today's life-sustaining technology, as exemplified by the pending "Baby Doe" legislation that would turn decisions now made by parents and their doctors over to the government and the courts. The second area involves the cost of health care. Medical costs have soared from $42 billion in 1965 to $300 billion today, a per capita leap from $211 to $1,225. In 1982 alone, medical costs climbed by 12 percent compared to the Consumer Price Index increase of only 4 percent.

As a consequence, public health programs are being curtailed and Medicare is threatened with bankruptcy within 6 years. These kinds of problems are already causing political stress. Constituent pressure on Congress to do something about the cost and availability of medical care is growing.

Even an outmoded idea such as a national health service is beginning to be discussed again, in spite of the fact that such a scheme would surely create more deficit spending. A British-style health system was once promoted in the U.S. for philosophic reasons; it is being revived today for economic reasons.

The Freshman Influence

When I arrived in the 98th Congress as one of 81 freshmen, I was uncertain how much influence I would be allowed to have on these issues. Although newcomers are still expected to mind their manners, I learned the opportunity now exists for every member to participate fully in the nation's legislative business. The late House Speaker Sam Rayburn's

* Dr. Rowland, a family practitioner from Dublin, GA, is now serving as Georgia's U.S. Congressman from the Eighth District. Send reprint requests to Congressman J. Roy Rowland, 513 Cannon House Office Building, Washington, DC 20515.



Congressman J. Roy Rowland of Dublin (right).

famous dictum that freshmen must ''go along to get along'' has faded into Congressional folklore.

This became clear early in the session when House Speaker Thomas P. ''Tip'' O'Neill, Jr., summoned all 57 Democratic freshmen to his spacious Capitol office and asked for a show of hands of those who opposed the budget resolution he was then pushing. Only five isolated hands were raised. Interestingly, three of the five belonged to Georgians, First District Rep. Lindsay Thomas, Third District Rep. Richard Ray, and myself. We felt the proposed spending levels were too high and our efforts should be directed toward a bipartisan effort to reduce the deficit.

Instead of being ostracized, however, the majority leadership listened to our views and continued to treat us fairly. (The resolution passed, but was later considerably toned down in a conference compromise.) Since then, a freshman coalition has become very active in seeking that elusive bipartisan approach to reducing the deficit.

If the leadership had exercised iron-fisted rule as in the past, I would never have succeeded in passing all three of the bills in the House that I introduced during my first year.

Those bills call for shifting methaqualone from Schedule II to Schedule I, for providing Veterans Administration benefits now denied veterans who suffer certain diseases after exposure to ionizing radiation in the military, and for renaming the Dublin VA Hospital in honor of the late Carl Vinson. The methaqualone and Vinson bills have been signed into law by President Reagan, and the ''atomic veterans'' compromise worked out with the Senate will, in all likelihood, be signed into law this year.

In addition to the improved position that freshmen have attained over the past few years, having a medical background has also been an advantage. For one thing, it gave me instant identity. Many of the 434 other members who didn't know the names of very many freshmen quickly learned a new physician was on board, and commonly began addressing me as ''Doctor'' or ''Doc.''

Two other doctors were serving in Congress when the session convened. One is Rep. Ron Paul of Texas, an OB-GYN, a Republican who ran for the Senate and was defeated in the primary. The other was Rep. Larry McDonald, the Georgia Democrat whose career was tragically cut short by the downing of the Korean airliner. I know of only two doctors, aside from myself, who were running for House seats in this year's elections, and both lost in primary elections.

Doctors in Congresses Past

Being a doctor in Congress is something of a novelty now. But that has not always been true. A total of 365 physicians have served in Congress since the First Continental Congress in 1774, according to the Library of Congress.

Many have been unusually distinguished. Dr. Lyman Hall, one of Georgia's signers of the Declaration of Independence, served in the Continental Congress. He was considered by many to be the most fervent supporter of the Revolution at a time when the colony was still lukewarm about the uprising. Dr. Manasseh Cutler, of Massachusetts, 1742-1823, who served two terms in the House, was one of the nation's greatest scholars, making contributions in navigation, botony, astronomy and literature, as well as medicine. Dr. Walter Judd of Minnesota, who served in the House during World War II until 1963, was a leading radio commentator, writer, diplomat, and lecturer on international relations.

But for some reason, the number of doctors in the House and Senate has been very gradually dwindling. An average of 12 to 18 physicians served in the nation's early Congressional sessions. That range was down to between seven and 15 by the second half of the 1800s. Throughout the 20th Century, we have had as few as two doctors and no more than five serving at any given time. According to our information, I will be the only physician returning next year, and this will be the first time in the nation's history that Congress will not have at least two or more doctors in its ranks.

Possibly because of the novelty factor, my opinion quickly began to be sought out on health issues. Sponsors of health bills began approaching me for support, and it became obvious that my opposition could possibly influence others and therefore should probably be reckoned with. This brought me into the action on many measures. While this attention was pleasing, I was reminded on a number of occasions that the influence of any member is limited.

This was brought home to me when I worked against the ''Baby Doe'' provisions of HB 1904 this year. When I had an opportunity to explain the negative aspects of the provisions at length, I was

able to turn votes around. Nevertheless, an amendment to delete the objectionable provisions failed, and the bill passed.

Current Issues Facing Medicine on the Hill

The AMA has done an outstanding job in Washington, including recently working out a compromise on the proposal to regulate physicians under the Federal Trade Commission. But more help was needed from physicians at the "grass roots" if the "Baby Doe" legislation was to be stopped in the House. A campaign of calls and letters from doctors throughout the country to their own Congressmen might have done the job. The "Baby Doe" legislation, by requiring a wide range of care and treatment for newborns with life-threatening birth defects, would have compelled physicians to practice the most defensive and costly medicine or risk charges of child abuse.

These concerns, however, eventually began to sink in. Compromise language was added in the Senate to make it clear that doctors would not be required to take extreme steps to keep handicapped infants alive if treatment was considered "virtually futile." Although this was an improvement, the language was still ambiguous and therefore potentially threatening to physicians. (The measure was pending in a House-Senate conference committee at the time of publication.)

While highly sophisticated life-support systems have given us wonderful advances in medicine, prolonging meaningful life for many, they have, on the other hand, in some instances presented complex problems concerning the decisions about their use. Technology has raised new ethical questions in medicine, and some of these questions run head-on into economic considerations.

Guidelines should be worked out by representatives of the appropriate government agencies, the medical profession, and other interested groups. At all costs, we should avoid turning decisions over to bureaucrats and lawyers that are properly in the hands of families, their clergy, and their doctors.

All kinds of problems are being caused by the rapid rise in medical costs. In 1981, for example, Congress directed the Social Security Administration to begin reducing the disability rolls to help bring the program into financial stability. Social Security officials went at it more aggressively than many in Congress anticipated. Some 470,000 people, whose cases were judged marginal, were expunged from the rolls, although 190,000 have since been reinstated under appeal. There has been a storm of protest from beneficiaries, and charges from Congressmen that the health of many of their constituents has been adversely affected. At long last, Congress is prepared to enact compromise legislation



which would restrict the wholesale removal of patients from the disability rolls. The House/Senate conferees have agreed on a procedure by which an individual would supply Social Security officials with sufficient medical information so that an informed decision can be made on the absence or presence of medical improvement before a recipient is removed from the rolls.

Costs are also having a dramatic impact on Medicare's Hospital Insurance Trust Fund. If costs and the aging population continue to increase at the current pace, the Fund would have a deficit of more than $200 billion sometime in the 1990s. But the Fund cannot have a deficit by law, and the program would have to be shut down within less than a decade if major changes were not enacted.

Congress has only applied a few bandaids to address this approaching crisis, like trimming $1.4 billion in 1981 by primarily raising beneficiaries' costs, cutting another $2.4 billion in 1982 by imposing strict reimbursement limitations on hospitals whose costs exceed the norm, and by adopting the "prospective payment" plan in March 1983. Under this plan, hospitals are reimbursed a specified amount based on the diagnosis of each patient rather than for actual costs. This is supposed to reward efficient hospitals and penalize those that exceed target payments. But as critics point out, the additional costs are likely to be passed along to privately-insured patients, thus fueling medical inflation.

An attempt to extend this "prospective payment" approach to doctors was made during the House consideration of the mandatory assignment provisions of the Deficit Reduction Act of 1984. Although I supported the portions of this proposal calling for a physician fee freeze (an action already voluntarily undertaken by the AMA), I argued against imposing mandatory assignment. Requiring

that physicians accept all Medicare patients on an assignment basis, in my opinion, would have resulted in a higher drop-out rate of participating doctors and reduced accessibility for the more rural patients. Fortunately, the mandatory assignment provisions were not adopted as part of the House-passed bill.

However, the conference agreement on the Deficit Reduction Act emerged with a 15-month freeze on fees by physicians for treating Medicare patients. The agreement addresses the problem of increased health care costs in a much more positive manner. Under the new law, doctors who increase their fees during this freeze will be penalized, while those who accept assignment will receive preferential treatment when the fee freeze is lifted. In addition, the names of these participating physicians will be made available to Medicare patients in a directory.

This is just one avenue that Congress has chosen thus far in an effort to reduce health care costs, but physicians' fees are by no means the only factor contributing to the rising cost of providing basic health care services.

The high cost of medicine can be attributed to a number of factors of course, including malpractice suits, improving technology, inflation, and a lack of incentives for patients, physicians, and hospitals to cut costs voluntarily.

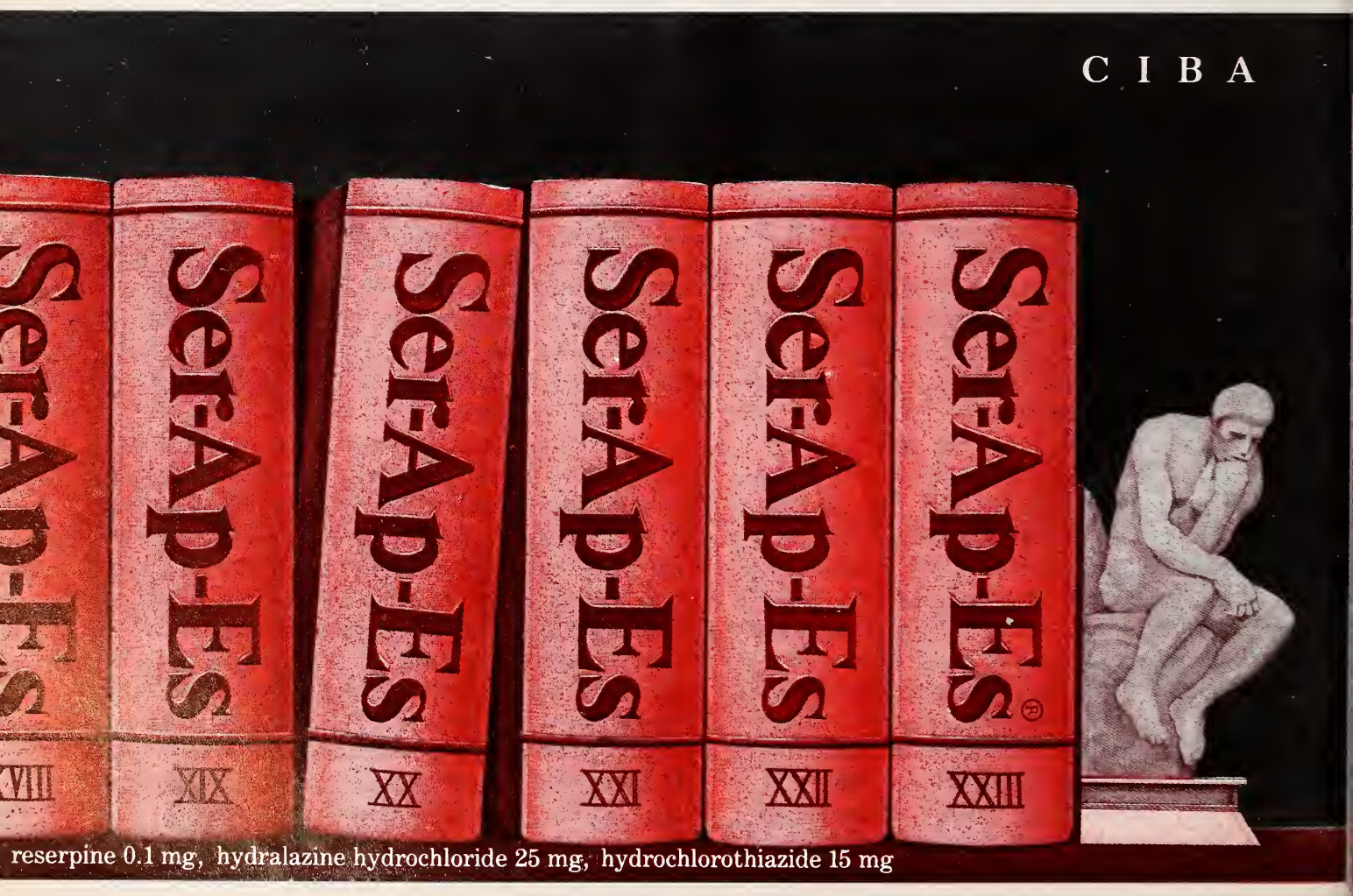
More than 90 percent of the American people are insulated from medical costs by government programs and private insurers. The new incentives currently proposed in Congress are not adequate. We need a thorough overhaul of the system.

We could save Medicare by simply raising the payroll taxes that finance the system or by cutting benefits. But placing too great of a burden on the public would not be politically acceptable or desirable.

Soon after I made a speech last year challenging Georgia's medical community to take the initiative in reforming our medical care system over the next few years, a longtime House member stopped me on the House floor and gave me some friendly advice. "Don't even try," he said. The system is so messed up, he observed, that Congress will delay any major restructuring as long as possible and will then do just enough to postpone the crisis.

I respectfully disagree. I have seen the interest and concern that exists in Congress over health issues. I have also seen a willingness to listen to medical professionals. With the full involvement of the medical community, I'm convinced we have an opportunity to make the necessary changes without increasing the role of government in our lives.

We still have a chance to rescue the best system the world has ever known.



To help prevent child abuse, physicians need to explore possibilities for leadership in practice settings and community programs as well as on administrative, political, and training levels.

Child Abuse: The Hidden Crime

BARBARA BRUNER, M.D., and SHERRY WARONKER, *Atlanta**

TWENTY-TWO YEARS AGO, C. Henry Kempe's article, "The Battered Child Syndrome," was published in the *Journal of the American Medical Association*. Many new findings have come to light since then. The phrase "battered child syndrome," although accurate, narrowly focused on the physical aspects of child abuse. Child abuse and neglect are now recognized as problems which are more pervasive than just physical injuries.

Physical injury is still a large problem in cases of child abuse, with the injuries ranging from bruises, burns, and broken bones to brain injury. The definition of child abuse, however, has been expanded to include sexual abuse, deprivation and neglect of children, abandonment, and emotional abuse. Although there are more of the latter problems seen than actual physical abuse, we still include all of these terms under "child abuse."

Abuse of all types is on the increase around the country, as is reporting of these incidents. According to information gathered by the Georgia Department of Human Resources' Division of Family and Children Services, there has been a remarkable increase in child abuse reports throughout the state. The increase in actual abuse is attributed to a variety of factors, such as unemployment, changes in the nuclear family, inflation, teenage parents, etc. Additionally, increased community awareness/knowledge about the problem of child abuse and changes in the community's attitude about getting involved have resulted in more people assuming responsibility for reporting cases in accordance with the law.

According to the Georgia Department of Human Resources, in FY 1983, more than 19,000 new cases of child abuse were reported in Georgia, an increase of 26 percent over 1982. Some 33,000 children were involved in these cases. Neglect comprised the majority of reports — 69 percent.

Neglect is the most prevalent form of abuse. Children who are neglected usually have caretakers who neither feed nor clothe them and allow them to starve, sometimes to death. The caretakers do not react with the children and both emotionally and physically neglect them. Some caretakers actually abandon the children, leaving them on the streets or unattended at home. Some, however, never neglect the child physically, but emotionally abuse them by teaching them very early that they have no worth.

Statistics indicate that there is not only more reporting but also more cases of child abuse occurring.

More reports of neglect are associated with lower income families, according to the Georgia Department of Human Resources (G-DHR). However, investigations reveal that in many instances the parents are not deliberately depriving their children of food and clothing out of neglect but because they are in economic straits and cannot afford such items.

Income changes can also influence the amount of physical child abuse. With changes in the economy in the last 5 to 8 years, there are definitely increases in the amount of abuse taking place. People who are limited by income and resources, who cannot afford proper daycare for their children, or who are out of jobs and at home with the children may become frustrated and can become potential abusers. With these people, any incident can trigger abuse.

The above factors are probably related to an increase of abuse in the lower socioeconomic group, but the physician must be well aware that all kinds of

* Dr. Bruner is a pediatrician, and Ms. Waronker is MAG's Assistant Director of Communications. Send reprint requests to Dr. Bruner at 69 Butler St., SE, Atlanta, GA 30303.

abuse can occur in middle and upper income families. Child abuse is not specifically income-related.

Younger children, aged 1 to 3, are at the highest risk for abuse than at any other age. Eight percent of all abuse cases involve children under 1 year of age, a higher percentage than for any other year of a child's life. The highest risk group for sexual abuse is children 13-15 years old. These findings are from data gathered by the G-DHR.

It is sexual abuse that is receiving the most attention in the media lately. This form of abuse includes rape, molestation, and child pornography. Sexual abuse crosses economic and social lines more so than any other type of abuse. It is the abuse least reported — probably only one in 10 cases is. With sexual abuse, as with other physical abuses, it is the physical injuries that confirm the abuse. This is another reason sexual abuse is hard to confirm. The problem with recognition of sexual abuse is that most younger children are not actually raped. Without the signs of penetration, there is not evidence of physical damage to the child and only a sexually transmitted infection would prove that any sexual abuse had occurred. In sexual abuse of young children, therefore, we must also look for changes in behavior such as mimicking sexual activity of which they should have no knowledge. Problems with enuresis, recurrent urinary infections, fecal soiling, etc., may indicate sexual abuse, especially sodomy.

Physicians can play a key role in discovering and reporting child abuse.

Incest, or familial sexual abuse, usually involves fondling in the younger child. Intercourse, as part of incestuous sexual abuse, is more common in the teenager, sometimes after an indefinite period of prior molestation, sometimes as the first manifestation. A teenage pregnancy may be the only clue to incest. The high incidence of female teenage runaways has been correlated with incest in many instances. A physician should not assume that a teenager who is pregnant or infected is that way because of a sex life of choice. She should be clearly asked whether or not the person who impregnated or infected her had sexual relations with her against her wishes and whether that person is a family member.

Physicians can play a key role in discovering and reporting child abuse because, at least with physical injury and sexual abuse, there are changes that occur in the child that often require medical attention. Many physicians, however, are reluctant to report abuse, although this is not as common as it once was. To avoid becoming involved, some private physicians and occasionally some working in hospital-based emergency rooms do not report suspected abuse but refer the child to another doctor. Unless the referring physician has the patient transported to the hospital or consultant, the case may not get followed up after leaving the first physician. A report may not be filed, and further abuse may occur because the patient may never arrive.

The law says that if a physician even *suspects* abuse, he must report it. He does not have to be sure that abuse has occurred. If he suspects that the possibility exists, he is mandated by law to report it. It is when he does *not* report suspected abuse that legal problems can occur. If a physician fails to make the report and it is revealed that a child was abused while in his care, the physician is subject to criminal action on the part of the county or state. He may also be subject to a civil suit brought by an uninvolved family member or a guardian-ad-litem for the child.

By law, all law enforcement, school, medical, daycare and social services personnel are required to report suspected cases of child abuse to the Georgia Department of Human Resources' Family and Children Services offices (county welfare offices). These professionals must report when they have "reasonable cause to believe" that a child has been abused. They do not have to have definite knowledge or proof. Records concerning reports of child abuse are confidential and are not available to the general public. As long as the report is made in good faith (without malicious intent), the professional is immune from liability. Although the threat of a lawsuit exists, it will most likely not hold up in court if the professional followed the law in reporting.

Regardless of this, many physicians are still wary of reporting abuse when they are not absolutely sure it has occurred. Besides the threat to his practice that a lawsuit would bring, the physician risks the often close relationship he has had with the child's family who may have been under his care for many years. In a small community, physicians have an even greater fear — the loss of community support and respect in the event of an unwarranted report.

Nevertheless, to help prevent child abuse, physicians need to explore possibilities for leadership in practice settings and community programs as well as on administrative, political, and training levels. As traditionally respected community leaders, physicians have the potential to garner public support and create public awareness of the seriousness of child abuse.

Any physician dealing with children should always consider the possibility of child abuse in cases of physical injury. The physician needs to consider the nature and pattern of the injury, the age and activity of the child, and whether the child is capable of the kind of actions that the parents said caused the injury. If abuse is suspected, the child needs immediate protection. Admission to the hospital may buy time to follow through on the mandated reporting and investigation undertaken by protective ser-

vices. In addition to guarding the child from further harm, this approach protects the abuser from causing more serious harm or death. There are few counties in Georgia with 24-hour service by protective services, and the child may be further injured or killed if sent home by the doctor. During daylight hours, protective services may be able to make alternative arrangements for the care of older children not injured seriously enough to require admission to a hospital.

The child, if old enough, should be questioned separately from the parents about both physical and sexual injury. Certain kinds of child abuse characteristically cause outlined patterns on the skin, multiple injuries of different ages, unexplained by a single reported event.

The Medical Association of Georgia and the Georgia Department of Human Resources have joined together in a statewide campaign for the prevention of child abuse in Georgia called, "It's OK to Tell." The intent of the campaign is to educate physicians and the general public about child abuse. Through this education, the campaign organizers hope to raise awareness of the problem and increase early reporting of abuse.

The purpose of recognizing and reporting is not only to protect that particular injured child but also to interrupt the pattern of behavior in the family that may lead to abuse of other children in the family. The physician may wish to continue a personal relationship with the family in which he would be supportive of psychologic or psychiatric counseling of the parent(s)/perpetrator(s). But he, in general, is neither trained for nor equipped in his office with personnel or adequate time to do this himself. Without protective services involvement, voluntary counseling is often interrupted without long-lasting effects in stopping abusive behavior. Mandatory, court-ordered, or supervised counseling is considered more effective according to some studies.

Currently, present confidentiality laws often frustrate the family physician who tries to obtain appropriate feedback about abuse cases from protective services. This should not negate his attempts at continuing the physician-patient arrangement if possible.

The prime aim of invertention in child abuse cases is rehabilitation of the entire family unit if possible. Reporting the case properly does not always mean that the children will or should be removed from the home, although in some cases, that may be the safest thing for the child on a temporary basis.

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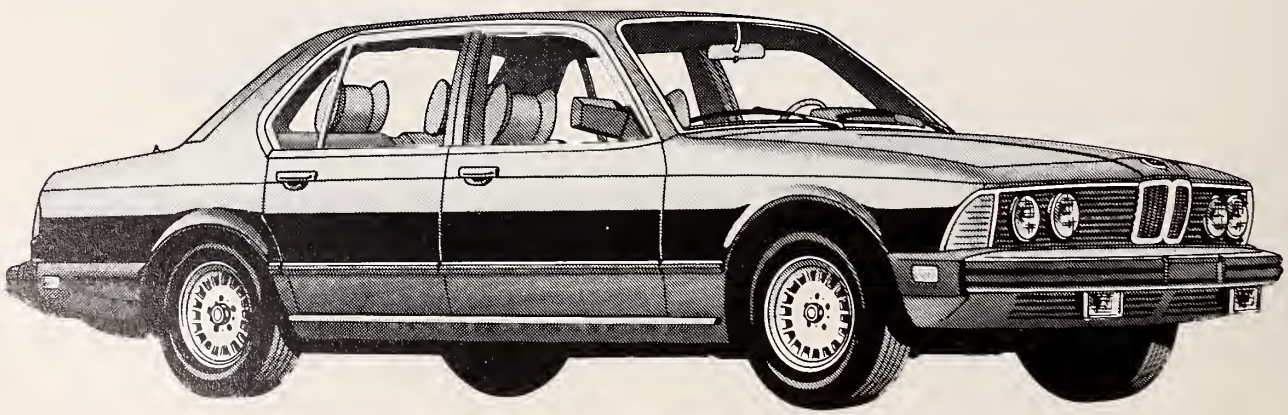
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Warnings: Peptic ulceration and GI bleeding, sometimes severe, have been reported. Ulceration, perforation and bleeding may end fatally. An association has not been established. Use *Motrin* Tablets under close supervision in patients with a history of upper gastrointestinal tract disease, after consulting ADVERSE REACTIONS. In patients with active peptic ulcer and active rheumatoid arthritis, try nonulcerogenic drugs, such as gold. If *Motrin* Tablets are used, observe the patient closely for signs of ulcer perforation or GI bleeding.

Chronic studies in rats and monkeys have shown mild renal toxicity with papillary edema and necrosis. Renal papillary necrosis has rarely been shown in humans treated with *Motrin* Tablets.

Precautions: Blurred and/or diminished vision, scotomata, and/or changes in color vision have been reported. If these develop, discontinue *Motrin* Tablets and the patient should have an ophthalmologic examination, including central visual fields and color vision testing.

Fluid retention and edema have been associated with *Motrin* Tablets; use with caution in patients with a history of cardiac decompensation or hypertension. In patients with renal impairment, reduced dosage may be necessary. Prospective studies of *Motrin* Tablets safety in patients with chronic renal failure have not been done.

Motrin Tablets can inhibit **platelet aggregation** and prolong bleeding time. Use with caution in persons with intrinsic coagulation defects and on anticoagulant therapy.

Patients should report signs or symptoms of **gastrointestinal ulceration** or bleeding, skin rash, weight gain, or edema.

Patients on prolonged **corticosteroid therapy** should have therapy tapered slowly when *Motrin* Tablets are added.

The antipyretic, anti-inflammatory activity of *Motrin* Tablets may mask inflammation and fever.

As with other nonsteroidal anti-inflammatory drugs, borderline elevations of liver tests may occur in up to 15% of patients. These abnormalities may progress, may remain essentially unchanged, or may be transient with continued therapy. Meaningful elevations of SGPT or SGOT (AST) occurred in controlled clinical trials in less than 1% of patients. Severe hepatic reactions, including jaundice and cases of fatal hepatitis, have been reported with ibuprofen as with other nonsteroidal anti-inflammatory drugs. If liver disease develops or if systemic manifestations occur (e.g. eosinophilia, rash, etc.), *Motrin* should be discontinued.

Drug interactions. *Aspirin:* used concomitantly may decrease *Motrin* blood levels.

Coumarin: bleeding has been reported in patients taking *Motrin* and coumarin.

Pregnancy and nursing mothers: *Motrin* should not be taken during pregnancy or by nursing mothers.

Adverse Reactions: The most frequent type of adverse reaction occurring with *Motrin* is gastrointestinal of which one or more occurred in 4% to 16% of the patients.

Incidence Greater than 1% (but less than 3%)—Probable Causal Relationship

Gastrointestinal: Nausea,* epigastric pain,* heartburn,* diarrhea, abdominal distress, nausea and vomiting, indigestion, constipation, abdominal cramps or pain, fullness of GI tract (bloating and flatulence); **Central Nervous System:** Dizziness,* headache, nervousness; **Dermatologic:** Rash* (including maculopapular type), pruritus; **Special Senses:** Tinnitus; **Metabolic/Endocrine:** Decreased appetite; **Cardiovascular:** Edema, fluid retention (generally responds promptly to drug discontinuation; see PRECAUTIONS).

Incidence less than 1%—Probable Causal Relationship**

Gastrointestinal: Gastric or duodenal ulcer with bleeding and/or perforation, gastrointestinal hemorrhage, melena, gastritis, hepatitis, jaundice, abnormal liver function tests; **Central Nervous System:** Depression, insomnia, confusion, emotional lability, somnolence, aseptic meningitis with fever and coma; **Dermatologic:** Vesiculobullous eruptions, urticaria, erythema multiforme, Stevens-Johnson syndrome, alopecia; **Special Senses:** Hearing loss, amblyopia (blurred and/or diminished vision, scotomata, and/or changes in color vision) (see PRECAUTIONS); **Hematologic:** Neutropenia, agranulocytosis, aplastic anemia, hemolytic anemia (sometimes Coombs positive), thrombocytopenia with or without purpura, eosinophilia, decreases in hemoglobin and hematocrit; **Cardiovascular:** Congestive heart failure in patients with marginal cardiac function, elevated blood pressure, palpitations; **Allergic:** Syndrome of abdominal pain, fever, chills, nausea and vomiting; anaphylaxis; bronchospasm (see CONTRAINDICATIONS); **Renal:** Acute renal failure in patients with pre-existing significantly impaired renal function, decreased creatinine clearance, polyuria, azotemia, cystitis, hematuria; **Miscellaneous:** Dry eyes and mouth, gingival ulcer, rhinitis.

Incidence less than 1%—Causal Relationship Unknown**

Gastrointestinal: Pancreatitis; **Central Nervous System:** Paresthesias, hallucinations, dream abnormalities, pseudotumor cerebri; **Dermatologic:** Toxic epidermal necrolysis, photoallergic skin reactions; **Special Senses:** Conjunctivitis, diplopia, optic neuritis; **Hematologic:** Bleeding episodes (e.g., epistaxis, menorrhagia); **Metabolic/Endocrine:** Gynecomastia, hypoglycemic reaction; **Cardiovascular:** Arrhythmias (sinus tachycardia, sinus bradycardia); **Allergic:** Serum sickness, lupus erythematosus syndrome, Henoch-Schonlein vasculitis; **Renal:** Renal papillary necrosis.

*Reactions occurring in 3% to 9% of patients treated with *Motrin*. (Those reactions occurring in less than 3% of the patients are unmarked.)

**Reactions are classified under *"Probable Causal Relationship (PCR)"* if there has been one positive rechallenge or if three or more cases occur which might be causally related. Reactions are classified under *"Causal Relationship Unknown"* if seven or more events have been reported but the criteria for PCR have not been met.

Overdosage: In cases of acute overdosage, the stomach should be emptied. The drug is acidic and excreted in the urine so alkaline diuresis may be beneficial.

Dosage and Administration: Rheumatoid arthritis and osteoarthritis. Suggested dosage is 300, 400, or 600 mg t.i.d. or q.i.d. Do not exceed 2400 mg per day. Mild to moderate pain: 400 mg every 4 to 6 hours as necessary.

Caution: Federal law prohibits dispensing without prescription. MED B-7-S

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J-4791 August, 1984



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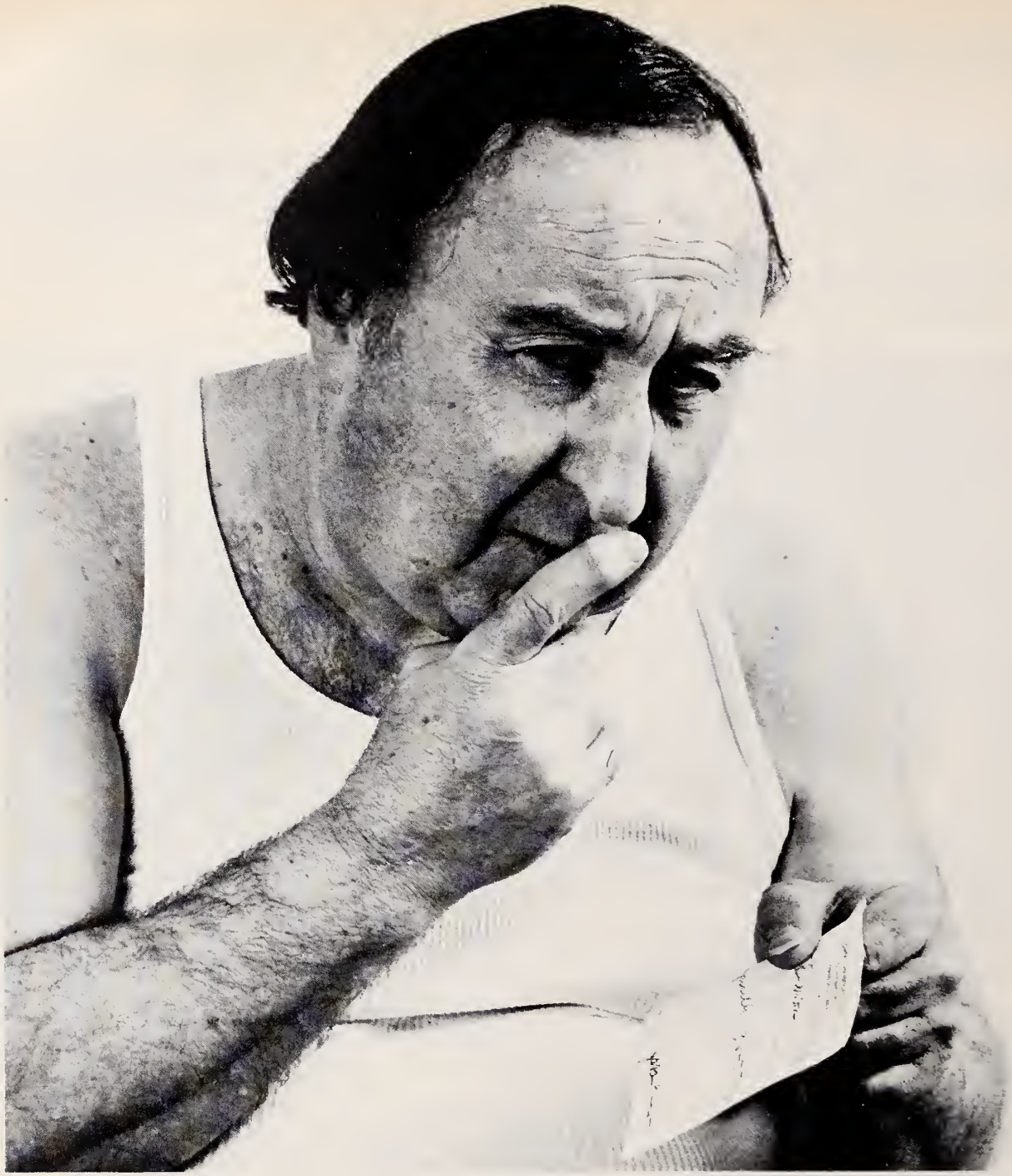
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■ *A message from the Food and Drug Administration.*

A review of the incidence, etiology, pathophysiology, and treatment of this disease is presented.

Spontaneous Pneumothorax

FRANK L. FERRIER, M.D., ***Atlanta****

History

In 1803, Itard recognized the clinical entity described as spontaneous pneumothorax, and in 1809, Laennec rendered the first complete clinicopathologic description of the disease.[1] Lindskog related this disease to emphysematous bulla formation in 1957.[2]

Incidence

The actual incidence of spontaneous pneumothorax is probably greater than the literature suggests, since not all practitioners report their cases and not all symptomatic individuals consult physicians. Approximately one out of every 1000 hospital admissions involves spontaneous pneumothorax;[2] however, this figure may be even higher if all varieties of spontaneous pneumothorax are considered, regardless of the patient's age or degree of infirmity. Approximately 5% to 7% of spontaneous pneumothoraces are bilateral, and 10% involve simultaneous bilateral collapse.[3] The rate of recurrence of spontaneous pneumothorax is said to be from 10% to 60% within the first 2 years; however, Gobbell noted this figure to be as high as 52% after the initial episode and 62% after the second episode.[4]

In the United States, patients most likely to develop a primary spontaneous pneumothorax are tall, asthenic, Caucasian males in their second decade of life. In other countries, however, stature is not reported to be as significant as the ratio of lung to body height.[5] The male-to-female ratio of occurrence is 8.5 : 1 under the age of 40.[6] After the age of 40, body habitus and sex do not correlate as well with the incidence of spontaneous pneumothorax. The risk factor seems to be increased in patients with abnormal thoracic anatomy, especially in those patients with greater lung height and a resultant long, narrow chest.[7]

Etiology

The most frequent cause of spontaneous pneumothorax is the rupture of an apical subpleural bleb that communicates with the tracheobronchial tree. In the past, pulmonary tuberculosis was noted as a frequent cause; however, it is now known that other chronic granulomatous disease states can produce an identical situation. Disease processes specific to the newborn infant can produce a spontaneous pneumothorax and pneumomediastinum. Trauma, neoplasm, connective tissue disease states, immune deficiency diseases, and hereditary disorders are incriminated with the development of a pneumothorax. Gynecologic causes include endometriosis of the pleura with pneumothorax during menstruation, choriocarcinoma, pregnancy, and on very rare occasions pulmonary lymphangiomyomatosis. Chemotherapy-induced pneumothorax occurs with tissue regression and/or necrosis of tumor tissue in the lung. It is not uncommon to see pneumothorax in association with general anesthesia, mechanical ventilation, and during or after radiation therapy. Changes in altitude associated with flying and diving may precipitate pneumothoraces in individuals with pre-existing pulmonary pathology. Finally, less common disease states such as multiple sclerosis and more bizarre congenital pleuropericardial defects have been associated with spontaneous pneumothorax.[8]

Pathophysiology

Certainly all patients with bullous disease of the lungs do not develop a pneumothorax; however, the degree of underlying lung pathology will determine

* Dr. Ferrier is a thoracic surgeon. This paper was prepared at the request of the Georgia Thoracic Society in Atlanta. Send reprint requests to Dr. Ferrier at 3250 Howell Mill Rd., NW, Ste. 303, Atlanta, Georgia 30327.

the severity of the pneumothorax. In a case involving a healthy young patient, there may be a rupture of a small apical emphysematous bleb or bulla. Rupture of a large segment of visceral parenchyma is sometimes seen in patients with severe underlying lung pathology. Using electron microscopy, Suzuki et al. studied various types of bullae according to the pathologic classification of Reid.[9] They found that absence or sloughing of mesothelial cells from underlying collagen fibers can cause bullae or blebs to rupture, resulting in pneumothorax.[10] Spontaneous bloody pneumothorax may develop when well-vascularized adhesions are attached to ruptured bullae, blebs, or cysts.[11] Rarely a hemothorax occurs without a pneumothorax.[12] Thus, the size, location, and pathologic characteristics of the visceral pleural defects plus the presence or absence of visceral parietal adhesions dictate the sequelae of a pneumothorax.

If a large portion of a lung collapses, an increase in intrapleural pressure may develop, such that a check-valve mechanism allows air to enter the pleural space during inspiration, yet no air can leave during expiration (tension pneumothorax). The relatively lower subatmospheric pressure on the opposite side allows for mediastinal shift away from the side of the pneumothorax, decreasing the effective lung volume of that lung. Further shifting of the mediastinum will ultimately impede venous inflow to the great veins of the heart, resulting in a decrease in cardiac output. The ensuing hypotension, hypoxemia, and hypoperfusion may result in permanent visceral organ injury.

Signs and Symptoms

Overt signs and symptoms of spontaneous pneumothorax may vary significantly. Frequently, the symptoms may be so mild that a healthy patient is unaware of any abnormality until a chest radiograph is obtained. However, in the patient with a tension pneumothorax or a simultaneous collapse of both lungs, there is usually the sudden onset of sharp, restricting chest wall (pleuritic) pain with or without a history of preceding exertion, and variable degrees of anxiety, dyspnea, and cough. Physical signs may include diminished breath sounds, decreased tactile fremitus, and hyperresonant percussion. If a hemothorax is present, a succussion "splash" may be elicited, and occasionally hemoptysis is present as well. Often, if there is a large air leak present, subcutaneous emphysema and/or tracheal deviation away from the side of the collapsed lung with associated findings of mediastinal shift may be detected. Chest radiograph is used to define the extent of lung involvement. The electrocardiogram may demonstrate transient ST segment elevation, particularly with left lung involvement.[13]

Nonsurgical Treatment

Various methods have been employed in the treatment of spontaneous pneumothorax, including simple bed rest with nasal oxygen. Clark et al. demonstrated that 1.25% of lung volume will return spontaneously per day;[14] thus, a 45% pneumothorax could require 36 days to resolve on room air without therapeutic intervention. In patients with less than 20% pneumothorax, chest radiograph performed 24 to 48 hours after simple observation will usually reveal complete re-expansion of the involved lung. Although needle aspiration has been recommended by some, the standard treatment for more severe pneumothorax is tube thoracostomy.[15, 16]

Tube Thoracostomy

Tube insertion is necessary in patients with greater than 20% collapse of the lung and/or radiographic evidence of more than 1.5 cm to 2 cm separation of the pleural surfaces. With a well-positioned chest tube, the lung usually re-expands immediately without suction.[17] If the air leak continues, underwater suction seal in the range of 15 cm to 20 cm may be applied. Rapid evacuation of air by forced suction has caused unilateral pulmonary edema. This phenomenon is most common in lungs that were collapsed for prolonged periods (greater than 3 days), resulting in a significant increase in the pulmonary extravascular water volume and decreased surfactant activity.[18, 19] If there is no evidence of air leak after suction has been discontinued, on the third or fourth day following closed thoracostomy the chest tube is first clamped for 24 hours and then usually removed the following day. It should be noted that in lieu of an underwater drainage system, a one-way (Heimlich) valve may be employed in the more simple cases of lung collapse. This device is inexpensive, safe, disposable, technically simple to attach, and allows prompt ambulation of the patient. Unfortunately, the valve has the potential for leakage and occlusion, the latter possibly resulting in tension pneumothorax.

There is no unanimity with regard to the chest tube size one must employ, although a tube smaller than size #22 to #28 French is rarely used for more severe pneumothorax in adults. Certainly the smallest effective tube is preferred, even though small tubes tend to kink (limit gas flow), become occluded with serum, blood, or parenchymal debris, and resist modification for suctioning. Large tubes rarely kink or obstruct and are easily adaptable to suctioning apparatus; however, they can cause more inflammation, promoting symphysis of the pleural surface. The #32 to #36 French straight Argyle chest tube is a personal preference.

Sterile techniques are employed for chest tube insertion. A small incision is made generally in the

fourth intercostal space along the midaxillary line; an alternative approach is the second intercostal space at the level of the midclavicular line. The tube is inserted with firm pressure into the intrapleural space, angled slightly toward the apex, sutured in place, connected to underwater drainage, and adapted for suctioning if necessary. Patients are maintained on antibiotics as long as the chest tube is in place.

A persistent pneumothorax is said to be present after 7-9 days of chest tube cannulation. In most cases, suction has been applied but the lung has not re-expanded, and a moderate air leak persists. If the chest tube is well-positioned and patent, bronchodilator therapy may be indicated in addition to diagnostic/therapeutic bronchoscopy to clear the tracheobronchial tree. Occasionally, simply changing the position of the patient may promote pleural symphysis. Not uncommonly with a large leak, one tube is not adequate to handle the air, and either a new tube or a second tube is required. Thoracoscopy performed at the time of tube repositioning, either through the old chest tube site or through a new site, may offer some explanation for uncontrolled air leaks and may dictate the use of additional therapeutic maneuvers.

Recurrent pneumothoraces will usually develop within 2 years following the initial collapse of a lung and are often treated with the insertion of a chest tube; if the lung does not remain expanded, then surgery is necessary.

Intrapleural Chemical Sclerosis

The concept of the creation of an intrapleural chemical pleuritis is not new.[20] Intrapleural chemical sclerosis utilizing tetracycline 500 mg with 50 cc sterile saline was first used in the treatment of malignant pleural effusions.[21] In 1979, Fox and Goldzer successfully extended this application for persistent as well as recurrent spontaneous pneumothorax.[22, 23] Since then, pleurodesis with substances such as hypertonic glucose,[24] iodized talc,[25] silver nitrate,[26] kaolin,[27] quinacrine hydrochloride (Atabrine),[28] nitrogen mustard, human fibrinogen cryoprecipitate (Fibrin adhesive),[29] olive oil,[30] and talc poudrage[31] has been used to initiate chemical pleuritis and thus prevent recurrence of spontaneous pneumothoraces. Common complications with chemical pleurodesis include local toxicity (especially with Atabrine overdose), relative inadequacy and nonuniformity of the developing adhesions, and long-term side effects of various drugs. When placed intrapleurally, tetracycline produces limited side effects including chest wall pain, fever for 24 to 36 hours, and pleural exudate. The question arises as to the effect chemical pneumonitis and bronchitis have on bronchopleural fistula when drugs are used as a therapeutic modality. Nonetheless, the application of intrapleural tetracycline as a prophylactic measure in inoperable patients creates some degree of intrapleural chemical sclerosis.

Surgical Treatment

The appropriate time for surgical intervention should be carefully individualized in patients with persistent air leaks. Surgery should be considered after 7-10 days of aggressive therapy, since the bronchopleural fistula may not close.

Indications for surgery include persistent pneumothorax, a third recurrent ipsilateral pneumothorax (some authors consider the second occurrence), massive uncontrolled air leak (e.g., subcutaneous emphysema, pneumomediastinum producing upper airway obstruction),[32] hemothorax with persistent bleeding, tension pneumothorax with well-positioned chest tube, a second current ipsilateral pneumothorax with previous contralateral pneumothorax, a second ipsilateral pneumothorax in medically at-risk groups, a second simultaneous bilateral pneumothorax, and a second pneumothorax in specific at-risk occupational groups (some authors consider first occurrence). The objectives of surgical treatment include complete re-expansion of the involved lung, control of any complications, and prevention of recurrence. The standard posterolateral incision is usually employed; however, many authors have suggested the anterior, modified anterior, transaxillary, or the mediasternotomy approach. Among the most common surgical procedures are bullectomy, pleurodesis, and pleurectomy (alone or in combination).

Bullectomy with partial resection of the lung includes local wedge excision of the involved apical bulla using a stapler device or oversewing the bullae or cysts. In cases of poor expansion of the lung following bullectomy or with a chronically collapsed lung, release of the parietal pleura (pleural tent) is sometimes necessary. If the lung has been collapsed for an extended period of time and a peel develops around the visceral pleura, decortication may be necessary.

Mechanical pleurodesis is accomplished by rubbing the parietal pleura (mainly at the apex) with a gauze sponge or pledget. An open chemical pleurodesis can also produce an effect similar to that of closed chemical pleurodesis. The inflammatory response typically produces adhesions that stick to the visceral pleura. Pleurodesis is frequently combined with bullectomy.

Pleurectomy is the removal of a portion of the parietal pleura, leaving the endothoracic fascia to interact with the visceral pleura. This produces uniform adhesions but makes any subsequent surgery more difficult. This procedure is not without compli-

cations; postoperative bleeding from the chest wall may result, requiring re-exploration for clot removal. Although this technique is felt to be too aggressive by some, recurrent spontaneous pneumothorax following bullectomy and parietal pleurectomy is rare. In addition, postoperative pulmonary function studies have revealed no significant impairment of the mechanical efficiency of respiration following pleurectomy.[33-35]

Surgical technique is a matter of choice. Each decision should be made to match the specific needs of the patient at the time of surgery. If small recurrent or persistent bronchopleural fistula is present, simple bullectomy is the procedure of choice. Conversely, if there is evidence of severe "honeycomb lung," lymphoangioleimyomatosis, diffuse subpleural disease, or if bullous periacinous emphysema is present, the most aggressive surgical techniques must be instituted to prevent recurrent pneumothorax.

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Adjunct in short-term treatment of pain accompanied by tension and/or anxiety in patients with musculoskeletal disease. Clinical trials demonstrated that in these situations relief of pain is somewhat greater than with aspirin alone. Effectiveness in long-term use, i.e. over 4 months, has not been assessed by systematic clinical studies. Physicians should periodically reassess usefulness of drug for individual patients.

CONTRAINDICATIONS:
ASPIRIN: Allergic or idiosyncratic reactions to aspirin or related compounds.

MEPROBAMATE: Acute intermittent porphyria; allergic or idiosyncratic reactions to meprobamate or related compounds, e.g. carisoprodol, mebutamate, or carbromal.

WARNINGS:
ASPIRIN: Use salicylates with extreme caution in patients with peptic ulcer, asthma, coagulation abnormalities, hypoprothrombinemia, vitamin K deficiency, or those on anticoagulants. In rare instances, aspirin in persons allergic to salicylates may result in life-threatening allergic episodes.

MEPROBAMATE: DRUG DEPENDENCE: Physical and psychological dependence, and abuse have occurred. Chronic intoxication from prolonged ingestion of, usually, greater than recommended doses is manifested by ataxia, slurred speech, and vertigo. Therefore, carefully supervise dose and amounts prescribed and avoid prolonged use, especially in alcoholics and others with known propensity for taking excessive quantities of drugs. Sudden withdrawal after prolonged and excessive use may precipitate recurrence of preexisting symptoms, e.g. anxiety, anorexia, or insomnia, or withdrawal reactions, e.g., vomiting, ataxia, tremors, muscle twitching, contusional states, hallucinosis, and, rarely, convulsive seizures. Such seizures are more likely in persons with CNS damage or preexistent or latent convulsive disorders. Onset of withdrawal symptoms occurs usually within 12 to 48 hours after discontinuation; symptoms usually cease within next 12- to 48-hour period. When excessive dosage has continued for weeks or months, reduce dosage gradually over 1 to 2 weeks rather than stop abruptly. Alternatively, a short-acting barbiturate may be substituted, then gradually withdrawn.

POTENTIALLY HAZARDOUS TASKS: Warn patients meprobamate may impair mental or physical abilities required for potentially hazardous tasks, e.g., driving or operating machinery.

ADDITIVE EFFECTS: Since CNS-suppressant effects of meprobamate and alcohol or meprobamate and other psychotropic drugs may be additive, exercise caution with patients taking more than one of these agents simultaneously.

USAGE IN PREGNANCY AND LACTATION: An increased risk of congenital malformations associated with minor tranquilizers (meprobamate, chlordiazepoxide, and diazepam) during first trimester of pregnancy, has been suggested in several studies. Because use of these drugs in early pregnancy, their use during this period should almost always be avoided. The possibility that a woman of childbearing potential may be pregnant at time of institution of therapy should be considered. Advise patients if they become pregnant during therapy or intend to become pregnant to communicate with their physicians about desirability of discontinuing the drug.

Meprobamate passes the placental barrier. It is present both in umbilical-cord blood at or near maternal plasma levels and in breast milk of lactating mothers at concentrations two to four times that of maternal plasma. When use of meprobamate is contemplated in breastfeeding patients, consider the drug's higher concentration in breast milk as compared to maternal plasma levels.

USAGE IN CHILDREN: Keep preparations with aspirin out of reach of children. Equagesic® (meprobamate with aspirin) is not recommended for patients 12 years of age and under.

PRECAUTIONS:
ASPIRIN: Salicylates antagonize uricosuric activity of probenecid and sulfinpyrazone. Salicylates are reported to enhance hypoglycemic effect of sulfonylurea antidiabetics.

MEPROBAMATE: Use lowest effective dose, particularly in elderly and/or debilitated, to preclude over-sedation. Meprobamate is metabolized in the liver and excreted by the kidney, to avoid excess accumulation exercise caution in its use in patients with compromised liver or kidney function. Meprobamate occasionally may precipitate seizures in epileptic patients. It should be prescribed cautiously and in small quantities to patients with suicidal tendencies.

ADVERSE REACTIONS:
ASPIRIN: May cause epigastric discomfort, nausea, and vomiting. Hypersensitivity reactions, including urticaria, angioneurotic edema, purpura, asthma, and anaphylaxis may rarely occur. Patients receiving large doses of salicylates may develop tinnitus.

MEPROBAMATE: CNS: Drowsiness, ataxia, dizziness, slurred speech, headache, vertigo, weakness, paresthesias, impairment of visual accommodation, euphoria, overstimulation, paradoxical excitement, fast EEG activity.

GI: Nausea, vomiting, diarrhea.

CARDIOVASCULAR: Palpitation, tachycardia, various forms of arrhythmia, transient ECG changes, syncope, hypotensive crisis.

ALLERGIC OR IDIOSYNCRATIC: Milder reactions are characterized by itchy, urticarial, or erythematous maculopapular rash, generalized or confined to the groin. Other reactions include leukopenia, acute nonthrombocytopenic purpura, petechiae, ecchymoses, eosinophilia, peripheral edema, adenopathy, fever, fixed drug eruption with cross-reaction to carisoprodol, and cross-sensitivity between meprobamate/mebutamate and meprobamate/carbromal. Rare, more severe hypersensitivity reactions include hyperpyrexia, chills, angioneurotic edema, bronchospasm, oliguna, and anuria. Also, anaphylaxis, exfoliative dermatitis, stomatitis, and proctitis. Stevens-Johnson syndrome and bullous dermatitis have occurred.

HEMATOLOGIC (SEE ALSO "ALLERGIC OR IDIOSYNCRATIC"): Agranulocytosis, aplastic anemia have been reported, although no causal relationship has been established, and thrombocytopenic purpura.

OTHER: Exacerbation of porphyric symptoms.

DOSAGE AND ADMINISTRATION:
Usual dose is one or two tablets, 3 to 4 times daily as needed for relief of pain when tension or anxiety is present. Not recommended for patients 12 years of age and under.

OVERDOSAGE:
Treatment is essentially symptomatic and supportive. Any drug remaining in the stomach should be removed. Induction of vomiting or gastric lavage may be indicated. Activated charcoal may reduce absorption of both aspirin and meprobamate. Aspirin overdosage produces usual symptoms and signs of salicylate intoxication. Observation and treatment should include management of hyperthermia, specific parenteral electrolyte therapy for ketoacidosis and dehydration, watching for evidence of hemorrhagic manifestations due to hypoprothrombinemia which, if it occurs, usually requires whole-blood transfusions. Suicidal attempts with meprobamate have resulted in drowsiness, lethargy, stupor, ataxia, coma, shock, vasomotor and respiratory collapse. Some suicidal attempts have been fatal. The following data, reported in the literature and from other sources, are not expected to correlate with each case (considering factors such as individual susceptibility and length of time from ingestion to treatment), but represent usual ranges reported. Acute simple overdose (meprobamate alone): Death has been reported with ingestion of as little as 12 grams meprobamate and survival with as much as 40 grams.

BLOOD LEVELS:
0.5-2.0 mg percent represents usual blood-level range of meprobamate after therapeutic doses. The level may occasionally be as high as 3.0 mg percent.

3-10 mg percent usually corresponds to findings of mild-to-moderate symptoms of overdosage, such as stupor or light coma.

10-20 mg percent usually corresponds to deeper coma, requiring more intensive treatment. Some fatalities occur.

At levels greater than 20 mg percent, more fatalities than survivals can be expected.

Acute combined overdose (meprobamate with other psychotropic drugs or alcohol): Since effects can be additive, history of ingestion of a low dose of meprobamate plus any of these compounds (or of a relatively low blood or tissue level) cannot be used as a prognostic indicator.

In cases of excessive doses, sleep ensues rapidly and blood pressure, pulse, and respiratory rates are reduced to basal levels. Any drug remaining in stomach should be removed and symptomatic treatment given. Should respiration or blood pressure become compromised, respiratory assistance, CNS stimulants, and pressor agents should be administered cautiously as indicated. Diuresis, osmotic (mannitol) diuresis, pentoneal dialysis, and hemodialysis have been used successfully in removing both aspirin and meprobamate. Alkalinization of the urine increases excretion of salicylates. Careful monitoring of urinary output is necessary, and caution should be taken to avoid overhydration. Relapse and death, after initial recovery, have been attributed to incomplete gastric emptying and delayed absorption.

HOW SUPPLIED:
Scored tablets, bottles of 100; Redipak® strip pack 25's; Redipak® unit dose 100's; individually wrapped.

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Chronic pain, over time, is related more and more to conditioning factors resulting from the chronic pain experience, feeding back into the circumstances to produce more pain.

Status of Cancer Pain Management

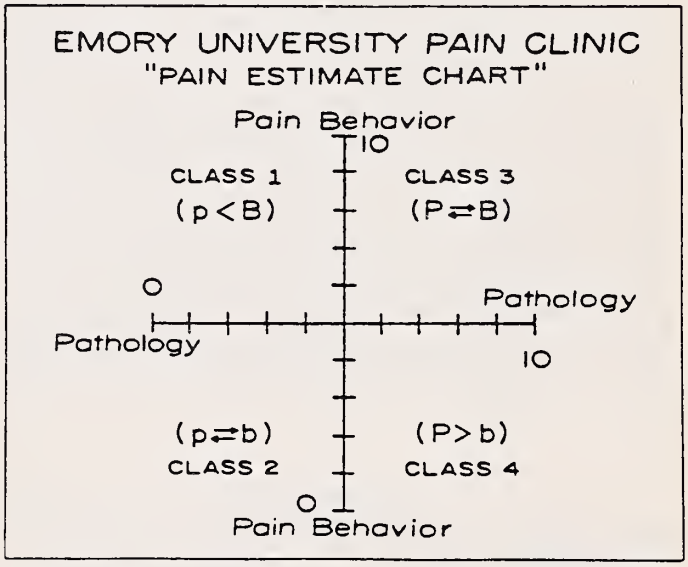
EDWARD E. SAMMONS, M.D., *Atlanta**

Approximately one-third of all patients who contract cancer today survive 5 years or more. According to a study on cancer rehabilitation done at the University of Washington,[1] pain is the fourth most common complaint in those with cancer and is the second most common remediable complaint. Those problems exceeding pain in frequency are psychologic problems, general weakness, and difficulties in performing normal activities of daily living.

Cancer pain can be considered chronic pain, and it is well to start with a definition of *acute* pain. Acute pain is related to definite nociception or tissue damage, such as occurs with trauma. Acute pain is a stimulus response phenomenon and disappears with correction of the pathologic problem and healing. *Chronic* pain may have characteristics of acute pain initially or from time to time during the chronic pain process. Chronic pain, over time, is related more and more to conditioning factors resulting from the chronic pain experience, feeding back into the circumstances to produce more pain. These consequences may be referred to as operant conditioning factors and are commonly related to excessive use of drugs of the narcotic, tranquilizer and hypnotic type, depression, musculoskeletal disuse, dependency or learned helplessness and secondary gain factors in the home, work, or financial area.

In the Emory University "Pain Estimate" Model,[2] chronic pain may be divided into four subgroups depending upon the degree of pathology and conditioning factors present (Figure 1).

It is essential to note that pathology and behavioral factors associated with chronic pain are two independent variables. The Emory "Pain Estimate"



Model shows pathology on the horizontal scale and pain behavior on the vertical scale. A Class I patient is one who has low pathology and high pain behavior including most, if not all, of the conditioning pain factors already mentioned. A Class II patient has low pathology and low pain behavior and is commonly called a "chronic complainer." A Class III patient has high pathology and high pain behavior; most cancer patients fit into this category. A Class IV patient is one who has high pathology, but low pain behavior and is commonly thought of as the stoic or "pain minimizer." A few cancer patients will fall into this category. It is also quite possible that some cancer patients cured of their problem by surgery, chemotherapy, radiation, or a combination of those common therapeutic regimens may fall into Class I or even the Class II category.

One of the most frequently asked questions which we at the Emory Pain Control Center hear from other physicians is, "Why do I do such a good job of curing disease and my patients still complain?" The

* Dr. Sammons, an anesthesiologist, is Assistant Professor of Medicine, Center for Rehabilitation Medicine of Emory University's Pain Control Center, 1441 Clifton Rd., NE, Atlanta, GA 30322.

answer is that conditioning factors are independent of pathologic factors. Because of our training as physicians, in which we consider pain complaints either related to an active disease process or to psychologic distortion, we fail to see the circumstances clearly or to understand what is happening. In addition to the five conditioning factors already mentioned, the cancer patient may have enormous physical and psychologic stress from such factors as general physical debilitation, bodily disfigurement, dread of the advancement of the disease, despair as to the ultimate outcome, and actual involvement in the dying process.

The Pathologic Process of Cancer

A brief summary of the pathologic processes likely to be found in cancer patients is in order. Nervous tissues, blood vessels, hollow viscera, cutaneous tissues, and deep somatic structures, such as bones and joints, may all be affected by compression, infiltration, occlusion, torsion, infection, and necrosis. In the management of chronic cancer pain, it is essential that treatment of the diagnosed pathologic factors be carried out in an active ongoing process. It should be emphasized that it is of utmost importance for the patient to be educated regarding what is happening with the choices for treatment. It is also essential that the patient understands the side effects and limitations of treatments chosen. In this manner, the patient becomes a participant in his own therapeutic process, with patient morale and cooperation being optimized.

Appropriate nerve block therapy may serve to assist the patient to break tension pain cycles and become more functional through physical therapy and relaxation techniques.

Regarding the nervous system pathways of chronic pain, mediation is by the slow C-fiber network much more so than the fast A-fibers. Acute pain results in immediate protective reflexes and is carried by the fast A-fibers. Chronic pain results in multiple stimulation at all levels of the spinal cord and, therefore, results in stimulus generalization. Vicious cycles of stimulus response patterns occur with more and more maladjustments, both physical and psychologic. Noxious inputs are increasingly likely to be exaggerated in their perception by the patient because of emotional maladjustments which proliferate. The agony of cancer pain and the multifaceted suffering seen is sustained by the multisynaptic afferent system and breakdown of pain inhibitory mechanisms with repetitive, abnormal firing in the central pool of neurons and conditioned responses poorly related to actual peripheral nociception. The chronic pain state, and this is particularly true in cancer patients, is the result of imbalance and maladjustment of the mind, body, and spiritual triad of the human being.

Managing Chronic Pain

Management of chronic pain patients requires recognition that cancer patients may fall in any of the four groups of chronic pain as shown on the Emory University "Pain Estimate" Model. Certainly most cancer patients fall into Class III. An extremely common problem is the failure on the part of most physicians to recognize that most patients with active pathologic processes can, at the same time and quite independently, have multiple behavioral factors taking place making the pain perception and experience much worse. It is worth reiterating that simple treatment of the pathologic processes, while behavioral factors are ignored, is probably the most important and common circumstance leading to mismanagement of chronic cancer pain. It does not take much special training to evaluate pathology and behavioral factors adequately and therefore, place the patient in the proper class from I to IV.

A combination of continued pathologic treatment with behavior modification in a capable pain control center can result in a patient who is better educated regarding the problem and has several perfectly appropriate skills which may be applied in a self-management setting to improve pain and increase function. The patient should be educated regarding proper drug use and explained the side effects of narcotic, tranquilizing, and hypnotic medications. Alcohol must be included as a hypnotic drug. The patient may then participate in the process of selecting appropriate medications and using them properly. It is our feeling that drugs should be given only on a time contingency basis and never on a p.r.n. system. This is for the purpose of minimizing or eliminating tolerance and addiction. Long-acting oral medications, such as methadone, combined with amitriptyline, is a good example of modification which can result in overall benefit to the patient. The patient should understand that pain relief is often bought at the expense of intellectual and physical function, and he may choose to put up with more pain in order to be more alert and functional. Through physical therapy, the patient can be coached to change and increase his daily activities in a proper manner and use various exercise regimens to overcome musculoskeletal pain which almost always accompanies any kind of chronic pain situation. Occupational therapy may instruct the patient in specific task performance, according to his physical limitations. Jacobson relaxation exercises may serve to reduce musculoskeletal pain and emotional tension, especially when combined with the

psychologic techniques of imagery. Group counseling with the patient and family, including staff personnel, such as psychologists, physicians, and pastoral counselors, may serve to decrease emotional tension, increase communication, provide support, and allay depression. Psychometric testing, using the MMPI, may help to identify emotional maladjustments, so that emphasis can be properly placed and attention given to these problems. Appropriate nerve block therapy may serve to assist the patient to break tension pain cycles and become more functional through physical therapy and relaxation techniques. It is worth noting at this point that cancer patients tend to respond very well to sympathetic nerve blocks and because of the usual existence of severe behavioral or conditioning factors, the placebo effect of nerve blocks often is heightened.

Management of Class IV patients is much easier than Class III and can be accomplished by education regarding the nature of the disease process, choices in treatment and expected side effects, and training and counseling regarding proper use of drugs, physical therapy, specific task performance, and relaxation techniques. The Class IV patient may indeed have psychologic needs and respond well to appropriate supportive and cognitive-directive therapy in a group setting.

We do not feel that ablative surgical procedures or neurolytic blocks have a strong place at all in cancer pain management. These should probably be limited to extreme and terminal situations in which the patient and family fully understand that they may well be trading pain relief for loss of sensory and motor function. It should be remembered and communicated to the patient that neurolytic procedures alter the inhibitory balance in the spinal cord and often result in intense numbness and burning pain within 2 weeks after the procedure is performed.

The Role of a Pain Control Center

A factor which should be definitely kept in mind as the cancer process continues is that of life expectancy. The complaining patient in whom the physician perceives that the cancer is under adequate control and who has high behavioral factors should certainly become a participant in a behavior modification program at a skilled pain control center. Those with active processes which may not be under control may still benefit enormously from a pain control center in which emphasis is placed on drug adjustment, physical therapy, specific task performance, relaxation techniques, and correction of the myriad psychologic and social problems associated with cancer. As the patient enters the terminal phase, it would be well to consider and discuss with the patient and family the possible use of a Hospice facility or in-home Hospice techniques to bring order, meaning, and control to the dying process. Death should be viewed not as a failure of the physician or of various therapeutic regimens but as the natural end to life experienced by all human beings. In a Hospice program, the patient's physical, psychologic, and spiritual needs may be attended to, so as to give the patient the best possible environment in which to experience the value and meaning of both life and death. The physician should remember that it is his responsibility and lot to cure only a few, to help many, but to be able to give comfort and love to all.

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Any serious effort to address the health care needs of minorities must also address the critical shortage of minority physicians.

The Morehouse Perspective on Physician Manpower Needs in Georgia

LOUIS W. SULLIVAN, M.D., ***Atlanta****

On June 16, 1983, in Washington, D.C., the Association of Minority Health Professions Schools released a study, *Blacks and the Health Professions in the 80s: A National Crisis and a Time for Action.*[1]

The study was funded by the Robert Wood Johnson Foundation. The health manpower data presented in the study include medicine, dentistry, pharmacy, and veterinary medicine. Most of the data and trends reported in the study are on blacks because such data are more readily available and more complete than are data on other underrepresented minorities in the health professions. However, the data on blacks appear to be qualitatively similar to those which are available on other underrepresented minorities.

The study documents the fact that, notwithstanding the projections of a surplus of physicians in the U.S. by 1990, the number and percentage of black and other minority physicians remain low, and the health status of black Americans is significantly poorer than that of white Americans. For example, in spite of varied efforts to increase the number of U.S. black physicians in the 1960s and 70s, the percentage increased by only 0.5% between 1950 and 1980, that is, from 2.1% in 1950 to 2.6% in 1980. This contrasts with the fact that blacks represent approximately 11.7% of the U.S. population. During those 30 years, the total number of U.S. physicians increased from 191,947 to 449,500, while the number of black physicians only increased from 4,026 to 11,700.

* Dr. Sullivan is President and Dean of the Morehouse School of Medicine in Atlanta. Send reprint requests to him at 720 Westview Drive, SW, Atlanta, GA 30310. This paper was presented at MAG's Leadership Conference Saturday afternoon program, "Training Future Physicians for the Competitive Medical Marketplace," in January, 1984.

Toward Increasing Minority Enrollment in Medical Schools

Intense efforts by medical schools to increase the enrollment of black and other minority students began some 15 years ago, in 1968, following the assassination of Martin Luther King, Jr. Until that time, the annual percentage of all minority freshman students had been less than 3%, with blacks comprising the largest minority group.

In 1970, the Association of American Medical Colleges adopted the recommendation of its Task Force on Minority Student Opportunities in medicine, that the percentage of freshman medical students who come from underrepresented minorities be increased to 12% by 1975-76. As a result of the efforts of most medical schools, and supported by significant federal funds for student financial aid and institutional programs, the number and percentage of medical students from *all* underrepresented minorities increased from 3.0% in 1968 to 10.0% in 1974-75. The percentage of black students increased from 2.7% to 7.5% during that period.

Since 1974-75, the number of minority freshman medical students has increased by less than 200, while the *total* number of medical school freshman has increased by 2,491. As a result, the percentage of minority freshman medical students declined to 9.4% by 1982, and the percentage of black freshmen decreased to 6.6% during that period. Thus, the laudable goal of 12% minority freshmen medical students has yet to be reached by U.S. medical schools.

During the 10-year period from 1971 to 1981, the number of places in the freshman class of U.S.

medical schools increased by 4,907, but the number of minority freshman medical students increased by only 508, of which 314 were black. Thus, during this decade, the opportunity was lost to significantly increase the number of underrepresented minority medical students *without decreasing* the number of medical school places available to white students.

In Georgia, where 27% of our citizens are black, less than 3% of our physicians are black. This fact was noted by the Health Planning Committee of the State of Georgia, in its 1969 report on the status of physician manpower in Georgia.[2]

Morehouse School of Medicine Opened

It is because of this shortage of black physicians in Georgia that efforts began in 1969 which led to the opening of the Morehouse School of Medicine in 1978, with a curriculum in the basic medical sciences. Morehouse is the first minority medical school to be founded in the 20th century.

From its inception, the Morehouse School of Medicine has enjoyed the support of both black and white physicians in Georgia and has been endorsed by the Medical Association of Georgia and the Georgia State Medical Association. We have also received the support and cooperation of the Medical College of Georgia and Emory University Medical School.

The shortage of blacks on the faculties of U.S. medical schools and the low percentage of black physicians in practice has resulted in a lack of sufficient role models for young black people who might aspire to become physicians.

In June, 1981, the Morehouse School of Medicine received authorization from the Georgia Department of Education to award the M.D. degree, and thus is now in transition to a four-year, M.D.-degree granting institution. On July 1, 1981, the Morehouse School of Medicine became independent from Morehouse College, and on July 1, 1983, the School of Medicine became the seventh institutional member of the Atlanta University Center. In cooperation with Emory University Medical School, in July, 1983, our third-year students began their clerkship training in Grady Memorial Hospital, integrated with the third-year Emory medical students.

Morehouse will award the M.D. degree for the first time in June, 1985.

The first three classes admitted to Morehouse transferred at the end of their 2-year basic sciences program to Emory, the Medical College of Georgia, and other medical schools for the completion of their undergraduate medical education.

Health Status of Black Americans

The Association's study shows that the health status of black Americans is significantly poorer than that of white Americans. The average life expectancy for black Americans is 5 years less than that of white Americans, and infant mortality for blacks is 21.4/1000 live births, compared with 11.8/1000 live births for whites. However, these averages for the U.S. do not reveal some rather striking data for some geographic locations. For example, in Georgia today, the life expectancy of blacks is 8.4 years less than that for whites. In six rural counties in Georgia, the life expectancy for black males is only 49.6 to 51.5 years, whereas in those same counties, the life expectancy for white males if 59.5 to 69.5 years, a difference in life expectancy as much as 18 years.[3] The life expectancy of the male population in Kenya is 51.3 years, exceeding that of black males in some rural Georgia counties.[4]

In 1980, in almost one third of the counties in Georgia (50/159), the infant mortality rate for blacks was higher than 30/1000 live births; and in 10% of Georgia's counties, the infant mortality rate was higher than 43/1000 live births.[3] The incidence of diabetes, arthritis, cancer, anemia, and other diseases is significantly higher for blacks than for whites. The study shows that urban blacks are more likely than urban whites to be without a regular source of health care and must travel longer and farther for care.[1]

It is recognized that a number of factors influence the health status of individuals and populations, such as family income, nutrition, lifestyle, environmental factors, and others. However, in addressing the health status of blacks and other minorities, one mitigating factor is the availability and utilization of physicians. Our nation's history has shown that, in our ghettos and barrios, the likelihood of a physician establishing his or her practice there is enhanced if that individual is from the same ethnic minority. This is not to suggest that health care for each ethnic group should be the sole province of health professionals from that same ethnic group. It is a simple realization of the social patterns that exist today. Thus, any serious effort to address the health care needs of minorities must also address the critical shortage of minority physicians.

Addressing Problems and Finding Solutions

The study points out the continuing shortage of blacks on the faculties of U.S. medical schools. This, combined with the continuing low percentage of black physicians in practice, has resulted in a lack of sufficient role models for young black people, who might aspire to become physicians.

Severe reductions in student financial aid over the past few years have resulted in increasing debt bur-

dens at high interest rates for all students.[5] This has erected a particularly threatening barrier to a medical education for low income students and those from minority backgrounds.

The study shows that U.S. medical schools have had widely varying results in their efforts to recruit and admit black students. Some 23% of U.S. black students enrolled in medical school in 1981-82 were in the four predominantly black schools: Morehouse, Meharry, Drew, and Howard. An additional 33% of the black medical students were enrolled in 21 predominantly white medical schools — i.e., less than 20 percent of U.S. medical schools enrolled 56 percent of the black medical students. Six of the nation's medical schools had no black students, and 75 (59 percent) had a black student enrollment of less than 5 percent. Thus, two thirds of the nation's medical schools each have 5% or fewer black students.

A strong commitment by the Georgia University System Board of Regents and Trustee Boards of our private medical schools is needed to implement more effective policies to increase black student enrollment.

The predominantly white schools which have had the greatest success are distributed in all geographic regions of the country and include public and private schools alike. Similarly, those schools which have had the least success are in all regions of the country.

The convergence of these factors has resulted in a plateau and a drop in the percentage of enrolled black medical students in U.S. schools since the peak enrollment percentages in 1974-75.

Serious and sustained efforts are needed to expand the size of the applicant pool of black and other minority students for medicine. Efforts must be made to improve the quality of academic preparation of minority young people in our nation's high schools and colleges.[6-8]

The report raises a series of issues and options regarding an increase in black health manpower in an era of projected manpower surplus, the reasons the goals of increased black health manpower were not achieved, the need for minority schools, the need for federal and state roles, and options for policy makers to consider:

> While there may be an emerging surplus of health manpower in many fields, there is no surplus of black health manpower in Georgia or the other 49 states. According to projections by the U.S. Department of Health and Human Services, beyond the year 2000, wide disparities will continue between the ratio of black manpower to black population and white manpower to white population. Many health manpower shortage areas have large black populations, including urban and rural areas in Georgia.
>
> An increase in the proportion of black physicians is dependent on a number of factors:
>
> — The commitment of majority medical schools.
> — The admissions and retention policies of all of our medical schools.
> — Improved high school and college science training for black students.
> — Affordable student financing.
>
> Strategies to increase the number of black students enrolled in all of our medical schools in Georgia include:
>
> — A strong commitment by the Georgia University System Board of Regents and Trustee Boards of our private medical schools to implement more effective policies to increase black student enrollment.
> — Increased scholarships and low interest loans for minority students.
> — A more aggressive policy of enforcement of affirmative action programs.
> — Training of more minority faculty and minority faculty development.

While there may be an emerging surplus of health manpower in many fields, there is no surplus of black health manpower in Georgia or the other 49 states.

In summary, there is a substantial probability that previous modest gains in the number of black medical students and black physicians are being eroded and that this erosion will worsen during the 1980s unless action is taken to:

> Increase minority student financal support through scholarships and low interest loans.
>
> Increase the commitment of all schools to recruit and retain black students, even while the schools reduce general enrollment.
>
> Because of the importance of minority medical schools in addressing this problem in 1984, increased financial stability and clinical diversity of the minority medical schools, including the Morehouse School of Medicine, is needed, including the expansion of their clinical bases, particularly through new or enhanced VA and county/city hospital affiliations.

Our society, our medical schools in Georgia, and our state medical societies must not yield to fatigue or malaise in this effort. The problems are complex

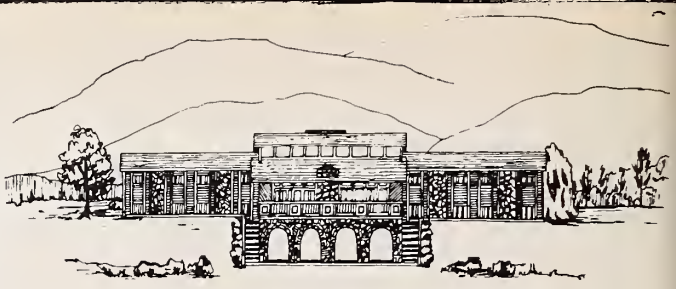
and so are the solutions. Whereas the problems are the result of many decades of segregation, discrimination, and unequal opportunity in our country, to achieve solutions will require long, sustained, and multiple efforts by all segments in our society. All of us, as individuals and as institutions, must contribute to these efforts.

The Medical Association of Georgia, representing the state's physicians in its appropriate role of leadership on health matters in the state, must play a leading role in these efforts. As the MAG works to expand and extend its influence in the resolution of our state's major health issues, the problems outlined in the study must be addressed.

The solutions can be found and ways can be identified with your leadership, commitment, and support.

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MAG Scientific Assembly 1984

PRELIMINARY PROGRAM

REGISTRATION INFORMATION

Your registration form for the 1984 MAG Scientific Assembly may be found in this issue of the *Journal*. If you need other forms, call the MAG office in Atlanta (876-7535 or toll free in Georgia: 800/282-0224). We will gladly mail you as many as you need. Early registration is advised. General Registration desks will also be open during the Scientific Assembly.

REGISTRATION FEE FOR PHYSICIANS

Surgery SESAP Course Only — MAG or ACS Member: $100; Non-member: $125. Other Specialty Programs — MAG member: $50; Non-member: $75.

There is no registration fee for the Hemophilia Symposium for Providers. If you plan to attend the luncheon session, please mail your check for $5 to Hemophilia of Georgia, Inc., 241 West Wieuca Road, N.E., Atlanta 30342.

There is NO FEE for resident physicians, medical students, program chairmen, or speakers.

Registration fee for other health professionals is $20.

HOTEL RESERVATIONS

If you wish hotel accommodations, please complete and detach the bottom portion of the registration form and mail it directly to the Ritz-Carlton Buckhead Hotel. Reservations received after November 16 will be met on a space-available basis.

ALLERGY
FRIDAY AFTERNOON

ALLERGY AND IMMUNOLOGY SOCIETY OF GEORGIA

PROGRAM CHAIRMAN:
Thomas F. Smith, M.D., Atlanta

FACULTY:

Tesheem K. Chaudhary, M.D.
Fellow, Section of Allergy and Immunology
Medical College of Georgia School of Medicine
Augusta

Stanley M. Fineman, M.D.
President
Allergy and Immunology Society of Georgia
Marietta

Carla H. Ingold, M.D.
Assistant Professor of Pediatrics
Division of Allergy/Immunology
Emory University School of Medicine
Atlanta

Charles H. Kirkpatrick, M.D.
Head, Division of Clinical Immunology
National Jewish Hospital and Research Center
Denver, Colorado

Thomas F. Smith, M.D.
Assistant Professor of Pediatrics and Medicine
Chief, Division of Pediatric Allergy/Immunology
Emory University School of Medicine
Atlanta

Chester T. Stafford, M.D.
Associate Professor of Pediatrics and Medicine
Section of Allergy/Immunology
Medical College of Georgia School of Medicine
Augusta

FRIDAY, NOVEMBER 16

12:00-1:20 **LUNCHEON**
Sponsored by Physicians' Laboratory, a division of Smith-Kline Clinical Laboratories.

1:30-2:15 **IMMUNOLOGIC CONSIDERATIONS IN INFECTIOUS DISEASE**
Charles H. Kirkpatrick, M.D.

2:15-2:30 **SELECTIVE IgA DEFICIENCY: IMMUNOLOGIC FUNCTION OF ILL PATIENTS**
Carla H. Ingald, M.D.

2:30-2:45 **COLD URTICARIA ASSOCIATED WITH C4 DEFICIENCY: CASE REPORT AND REVIEW OF LITERATURE**
Chester T. Staffard, M.D.

2:45-3:00 **COFFEE BREAK**

3:00-3:45 **LABORATORY EVALUATION OF ALLERGIC AND IMMUNOLOGIC FUNCTION**
Charles H. Kirkpatrick, M.D.

3:45-4:00 **IgG SUBCLASSES AND ANTIBODY RESPONSES IN CHILDREN WITH CHRONIC CHEST SYMPTOMS**
Thamas F. Smith, M.D.

4:00-4:15 **TERFENADINE IN THE TREATMENT OF RAGWEED POLLINOSIS IN CHILDREN**
Tesheem K. Chaudhary, M.D.

4:15-4:30 **PRESIDENT'S ADDRESS**
Stanley M. Fineman, M.D.

4:30-5:30 **ANNUAL BUSINESS MEETING**

5:30 **RECEPTION FOR MEMBERS AND GUESTS**
Spansared by Baehringer-Ingelheim

Dr. Kirkpatrick's participatian is spansared by Key Pharmaceuticals. We alsa gratefully acknawledge suppart fram Center Labarataries; Ferndale Labaratary; Greer Labarataries; Geigy Pharmaceuticals; Hallister-Stier; and Scherling, Inc.

CHEST DISEASE ALL DAY FRIDAY AND SATURDAY MORNING

GEORGIA THORACIC SOCIETY
GEORGIA CHAPTER, AMERICAN COLLEGE OF CHEST PHYSICIANS
AMERICAN LUNG ASSOCIATION OF GEORGIA

PLANNING COMMITTEE:
Paul J. Scheinberg, M.D., Atlanta
R. Vaughn Maples, M.D., Augusta
Edwin A. Kramer, ALG Staff

FRIDAY, NOVEMBER 16
THE CHALLENGING PULMONARY INFECTION

FACULTY:

Layne O. Gentry, M.D.
Assaciate Prafessar af Medicine,
Microbialagy and Immunalagy
Baylar Callege of Medicine
Chief af Infectiaus Diseases
St. Luke's Haspital
Haustan, Tex.

Philip C. Hopewell, M.D.
Assaciate Prafessor af Medicine
University of Califarnia
San Francisca General Haspital
Chest Service Divisian
San Francisco, Calif.

Richard J. O'Brien, M.D.
Non-Tuberculasis Mycabacterial Diseases,
Epidemialagy and Treatment
Chief, Clinical Studies Divisian
Centers for Disease Cantral
Atlanta

David Rimland, M.D.
Assaciate Prafessar of Medicine
Divisian af Infectiaus Diseases
Emary University Schaal af Medicine
VA Hospital
Atlanta

Gerald W. Staton, Jr., M.D.
Assistant Prafessar af Medicine
Pulmanary Disease
Emary University Schaal af Medicine
Atlanta

Samuel E. Webster, M.D.
Clinical Practice
Infectiaus Diseases
Atlanta

9:00-10:00 **PULMONARY INVOLVEMENT IN THE ACQUIRED IMMUNE DEFICIENCY SYNDROME (AIDS)**
Philip C. Hopewell, M.D.

10:00-10:45 **ANTIMICROBIAL THERAPEUTIC CONSIDERATIONS IN THE CHALLENGING NOSOCOMIAL PNEUMONIAS**
Layne O. Gentry, M.D.

10:45-11:00 **COFFEE BREAK**

11:00-12:00 **PANEL DISCUSSION**
Moderatar: Gerald W. Statan, Jr., M.D.

12:00- 1:30 **LUNCH BREAK**

1:30- 2:15 **PULMONARY TUBERCULOSIS, AN UPDATE**
Philip C. Hapewell, M.D.

2:15- 3:00 **NON-TUBERCULAR MYCOBACTERIAL PULMONARY DISEASES**
Richard J. O'Brien, M.D.

3:00- 3:15 **COFFEE BREAK**

3:15- 4:00 **FUNGAL PNEUMONIAS**
David Rimland, M.D.

4:00- 5:00 **CASE PRESENTATIONS AND PANEL DISCUSSION**
Maderatar: Samuel E. Webster, M.D.
Participants: Drs. Hapewell, Gentry, O'Brien and Rimland

5:00- 6:00 **RECEPTION — BUSINESS MEETING**
Geargia Tharacic Saciety and Geargia Chapter, American Callege af Chest Physicians

SATURDAY, NOVEMBER 17
EXERCISE IN PULMONARY REHABILITATION

FACULTY:

Alpha Berry Fowler, M.D.
Assistant Prafessar
Medical Callege of Virginia Haspital
Richmand, Va.

Ralph L. Haynes, M.D., F.A.C.P.
Director, Steiner Lung Clinic
St. Joseph's Hospital
Atlanta

Larry K. Jackson, M.D.
Pulmonary Section, Department of Medicine
University of Alabama
Birmingham, Ala.

William R. Kenny, M.D.
Medical Director of Respiratory Care
Piedmont Hospital
Atlanta

8:15- 8:30 COFFEE

8:30- 9:15 PHYSIOLOGY OF EXERCISE: AN UPDATE AND OVERVIEW
Larry K. Jackson, M.D.

9:15-10:15 EXERCISE TESTING IN PATIENTS WITH CHRONIC LUNG DISEASE
Alpha Berry Fowler, M.D.

10:15-10:30 COFFEE BREAK

10:30-11:15 PRACTICAL ASPECTS OF EXERCISE IN REHABILITATING PULMONARY PATIENTS
William R. Kenny, M.D.

11:15-12:00 PANEL ON EXERCISE IN REHABILITATION
Moderator: Ralph L. Haynes, M.D.
Participants: Drs. Jackson, Fowler and Kenny

We gratefully acknowledge the generous financial support of this program by Aerox, Respiratory Homecare Services, Inc. (a subsidiary of Aerox Healthcare Services, Inc.); Glasrock Medical Services; Key Pharmaceuticals, and Censor Medica Corp.

EMERGENCY MEDICINE SATURDAY MORNING

GEORGIA CHAPTER, AMERICAN COLLEGE OF EMERGENCY PHYSICIANS

The morning program on various management procedures in the Emergency Room will offer Category I ACEP credit.

GASTROENTEROLOGY FRIDAY AFTERNOON

GEORGIA GASTROENTEROLOGIC SOCIETY

PROGRAM CHAIRMAN:
Paul R. Rodzewicz, M.D., Atlanta
President
Georgia Gastroenterologic Society

FACULTY:
John T. Galambos, M.D.
Professor of Medicine
Director of Digestive Disease
Emory University School of Medicine
Atlanta

Steven J. Morris, M.D.
Clinical Associate Professor
Emory University School of Medicine
Atlanta

Francis J. Tedesco, M.D.
Chairman, Department of Medicine
Section of Gastroenterology
Medical College of Georgia School of Medicine
Augusta

FRIDAY, NOVEMBER 16

2:00-2:45 IMMUNOPROPHYLAXIS OF VIRAL HEPATITIS
John T. Galambos, M.D.

2:45-3:00 COFFEE BREAK

3:00-3:45 INFECTIOUS COLITIS: MIMICKING INFLAMMATORY BOWEL DISEASE
Francis J. Tedesco, M.D.

3:45-4:30 GASTROINTESTINAL MANIFESTATIONS OF ACQUIRED IMMUNE DEFICIENCY SYNDROME
Steven J. Morris, M.D.

4:30-5:00 QUESTIONS AND ANSWERS

SPECIAL FEATURE: HEMOPHILIA SYMPOSIUM FOR PROVIDERS SATURDAY MORNING

Program Chairmen for Hemophilia of Georgia, Inc., are Elna Phelan, M.D., of Atlanta, and C. Lawrence Lutcher, M.D., of Augusta.

A luncheon will follow this session and will include questions and answers with the faculty. Physicians attending this program and luncheon are not required to pay an MAG registration fee. Attendees instead should contact the office of Hemophilia of Georgia, Inc., 241 West Wieuca Road, N.E., Suite 104, Atlanta 30342. Please enclose your check for $5. Major funding for the luncheon is provided by Alpha Pharmaceuticals.

FACULTY:
Pamela Bertagnoll, RN, MN, MPH
Program Director
Hemophilia of Georgia
Atlanta

Bruce Evatt, M.D.
Chief, Host Factors Division
Centers for Disease Control
Atlanta

Michael Healey, D.D.S.
Pedodontist
Comprehensive Care Hemophilia Clinic
Scottish Rite Hospital for Crippled Children
Atlanta

Peter Levine, M.D.
Chief, Medical Division
Professor of Medicine
University of Massachusetts Medical School
Director
New England Area Comprehensive Hemophilia Center
Worcester, Massachusetts
Medical Co-Director
National Hemophilia Foundation

C. Lawrence Lutcher, M.D.
Chief of Hematology
Professor of Medicine
Medical College of Georgia
Augusta

Elna Phelan, M.D.
Pediatric Hematologist
Medical Director
Comprehensive Care Hemophilia Clinic
Scottish Rite Hospital for Crippled Children
Atlanta

SATURDAY, NOVEMBER 17

9:00- 9:05 WELCOME
Elna Phelan, M.D.

9:05- 9:50 CURRENT CONCEPTS IN HEMOPHILIA
Peter Levine, M.D.

9:50-10:05 DDAVP: A NEW APPROACH TO HEMOPHILIA
Elna Phelan, M.D.

10:05-10:15 COFFEE BREAK

10:15-10:35 MANAGEMENT OF INHIBITORS
C. Lawrence Lutcher, M.D.

10:35-10:50 DENTAL CARE FOR THE HEMOPHILIA PATIENT
Michael Healey, D.D.S.

10:50-11:20 EPIDEMIOLOGICAL AND ETIOLOGICAL CONSIDERATIONS OF AIDS
Bruce Evatt, M.D.

11:20-11:30 HEMOPHILIA CARE IN GEORGIA
Pamela Bertagnoll, RN, MN, MPH

NEUROLOGY
SATURDAY

GEORGIA NEUROLOGICAL SOCIETY

PROGRAM CHAIRMAN:
Mark A. Kozinn, M.D., Atlanta

FACULTY:

Herbert Schaunberg, M.D.
Albert Einstein Medical Center
New York, N.Y.

Thomas R. Swift, M.D.
Department of Neurology
Medical College of Georgia
School of Medicine
Augusta

SATURDAY, NOVEMBER 17

9:00-3:00 PERIPHERAL NEUROPATHY

NEUROSURGERY
SATURDAY MORNING AND SUNDAY MORNING

GEORGIA NEUROSURGICAL SOCIETY

PROGRAM CHAIRMAN:
Fleming L. Jolley, M.D., Brunswick

FACULTY:

Larry V. Carson, M.D.
Assistant Professor of Neurosurgery
Medical College of Georgia
School of Medicine
Augusta

Kemp Clark, M.D.
Chairman, Department of Neurosurgery
University of Texas Southwestern Medical School
Dallas, Tex.

Mark S. O'Brien, M.D.
Professor of Neurosurgery
Emory University School of Medicine
Atlanta

Stephen W. Schwarzmann, M.D.
Professor of Medicine
Emory University School of Medicine
Atlanta

SATURDAY, NOVEMBER 17

8:30- 8:45 CONTINENTAL BREAKFAST

8:45- 9:30 ANTIBIOTICS FOR INTRACRANIAL INFECTIONS
Stephen W. Schwarzmann, M.D.

9:30-10:15 INTRASPINAL EPIDURAL ABSCESSES
Kemp Clark, M.D.

10:15-10:30 COFFEE BREAK

10:30-11:15 COMPLICATIONS OF SHUNTS WITH PARTICULAR REFERENCE TO INFECTIONS
Mark S. O'Brien, M.D.

11:15-12:00 INTRACRANIAL SUPPURATION
Kemp Clark, M.D.

12:00-12:45 RECONSTRUCTIVE CRANIAL SURGERY — POSTINFECTIOUS PROCESSES
Larry V. Carson, M.D.

SUNDAY, NOVEMBER 18

8:30- 9:00 CONTINENTAL BREAKFAST

9:00-11:00 SOCIOECONOMIC PROGRAM
H. Dale Richardson, M.D., Atlanta
Ellis B. Keener, M.D., Gainesville
B. J. Anderson, J.D., Chicago, Ill.
Associate General Counsel,
American Medical Association

11:00-12:00 GNS BUSINESS MEETING
Presiding: Joseph C. Barnett, Jr., M.D., Marietta
President
Georgia Neurosurgical Society

OTOLARYNGOLOGY
HEAD AND NECK SURGERY
FRIDAY MORNING

GEORGIA SOCIETY OF OTOLARYNGOLOGY/ HEAD AND NECK SURGERY
GREATER ATLANTA SOCIETY OF OTOLARYNGOLOGY/HEAD AND NECK SURGERY

PROGRAM CHAIRMEN:
William E. Silver, M.D.
Albert A. Clairmont, M.D.

FACULTY:
G. Richard Holt, M.D.
Associate Professor of Surgery (Otolaryngology)
University of Texas Medical School
San Antonio, Tex.

Jonas A. Shulman, M.D.
Professor of Medicine
Emory University School of Medicine
Atlanta

William E. Silver, M.D.
Private Practice
Atlanta

N. Wendell Todd, M.D.
Assistant Professor of Otolaryngology
Emory University School of Medicine
Atlanta

FRIDAY, NOVEMBER 16

9:00- 9:05 INTRODUCTION
Albert A. Clairmont, M.D., and William E. Silver, M.D.

9:00- 9:20 THE PREVENTION AND TREATMENT OF INFECTIONS IN COSMETIC SURGERY OF THE HEAD AND NECK
William E. Silver, M.D.

9:20- 9:25 QUESTIONS AND ANSWERS

9:25- 9:50 THE ANTIBIOTIC AND SURGICAL MANAGEMENT OF ACUTE AND CHRONIC OTITIS MEDIA AND MASTOIDITIS
G. Richard Holt, M.D.

9:50- 9:55 QUESTIONS AND ANSWERS

9:55-10:10 COFFEE BREAK

10:10-10:35 THE CHOICE OF PROPHYLACTIC ANTIBIOTICS IN SURGERY OF THE HEAD AND NECK
Jonas A. Shulman, M.D.

10:35-10:40 QUESTIONS AND ANSWERS

10:40-11:05 ANTIBIOTIC AND SURGICAL MANAGEMENT OF ACUTE AND CHRONIC SINUSITIS
G. Richard Holt, M.D.

11:05-11:10 QUESTIONS AND ANSWERS

11:10-11:35 PEDIATRIC ASPECTS OF CROUP, EPIGLOTTITIS, RETROPHARYNGEAL ABSCESS
N. Wendell Todd, M.D.

11:30-11:40 QUESTIONS AND ANSWERS

PATHOLOGY
SATURDAY MORNING AND SUNDAY

GEORGIA ASSOCIATION OF PATHOLOGISTS
ATLANTA SOCIETY OF PATHOLOGISTS

SATURDAY, NOVEMBER 17

PROGRAM CHAIRMAN:
A. Bleakley Chandler, M.D., Augusta
President
Georgia Association of Pathologists

FACULTY:
James L. O'Quinn, M.D.
Humana Hospital
Augusta

Mary H. O'Quinn, M.D.
Humana Hospital
Augusta

9:00-10:00 INFECTIOUS DISEASES OF THE SKIN ENCOUNTERED IN THE SOUTHEAST

10:00-10:15 COFFEE BREAK

10:15-11:15 APPLICATION OF IMMUNOFLUORESCENCE TO THE DIAGNOSIS OF SKIN DISEASE

11:30-12:30 BUSINESS MEETING
Georgia Association of Pathologists

SUNDAY, NOVEMBER 18

PROGRAM CHAIRMAN:
Sara F. Nolting, M.D.
President
Atlanta Society of Pathologists

FACULTY:
Daniel H. Connor, M.D.
Chairman, Department of Infectious & Parasitic Disease Pathology
Armed Forces Institute of Pathology
Washington, D.C.

9:00-10:30 PATHOLOGY OF INFECTIOUS AND PARASITIC DISEASES
Daniel H. Connor, M.D.

10:30-11:00 COFFEE BREAK

11:00- 2:00 PATHOLOGY OF INFECTIOUS AND PARASITIC DISEASES (cont'd)
Daniel H. Connor, M.D.

Microscopic slide study sets, including clinical protocols, have been prepared for the 20 cases which Dr. Connor will present. Each set contains 33 slides, with hematoxylin and eosin as well as appropriate special stains. Limited sets are available for $60, and requests should be mailed to:

Sara F. Nolting, M.D.
Laboratory
Windy Hill Hospital
2540 Windy Hill Road
Marietta, Georgia 30067

Please make checks payable to "Atlanta Society of Pathologists."

PLASTIC SURGERY
SATURDAY MORNING

GEORGIA SOCIETY OF PLASTIC SURGEONS

PROGRAM CHAIRMAN:
W. Jefferson Pendergrast, M.D.

FACULTY:
George C. Peck, M.D.
Associate Clinical Professor of Plastic Surgery
College af Physicians and Surgeons
Columbia University
New York, N.Y.

SATURDAY, NOVEMBER 17

9:30-10:30 AUGMENTATION RHINOPLASTY
George C. Peck, M.D.

10:30-11:00 COFFEE BREAK

11:00-12:00 RECONSTRUCTIVE RHINOPLASTY
George C. Peck, M.D.

PSYCHIATRY
FRIDAY AFTERNOON

GEORGIA PSYCHIATRIC ASSOCIATION

PROGRAM CHAIRMAN:
John B. Griffin, Jr., M.D., Atlanta

FACULTY:
Alan J. Gelenberg, M.D.
Assaciate Professor of Psychiatry
Harvard Medical Schaol
Psychiatrist-in-Chief
The Arbor Hospital
Chief of the Special Studies Clinic
Boston, Mass.

FRIDAY, NOVEMBER 16
ADVANCED PSYCHOPHARMACOLOGY

1:00- 2:00 ANTIDEPRESSANTS
Alan J. Gelenberg, M.D.

Topics for discussion: new antidepressants; approaches to unresponsive depression; usefulness of antidepressant blood levels; indications for MAON inhibitors; use of tyrosine; treatment of depressed borderline patients; use of thyroid hormanes ar TSH; and combination of MAON inhibitors and tricyclic drugs.

2:00- 3:00 OTHER NEW DEVELOPMENTS IN PHARMACOLOGIC TREATMENT

3:00- 3:30 COFFEE BREAK

3:30- 4:30 ANTIPSYCHOTIC DRUGS
Alan J. Gelenberg, M.D.

Topics for discussian: overview of new antipsychotic drugs; combination therapy with lithium; neuroleptic malignant syndrame; tardive dyskinesia; use with non-psychotic patients; and use with carbamazepine (Tegretol).

SURGERY
FRIDAY AND SATURDAY

GEORGIA CHAPTER, AMERICAN COLLEGE OF SURGEONS

SESAP IV REVIEW COURSE. Ta meet expenses far this special program, including syllabuses provided by the American College of Surgeans, a registratian fee of $100 is being charged far MAG or ACS members; $125 for non-member physicians. Please mark the appropriate bax an the MAG Scientific Assembly registratian form.

FRIDAY, NOVEMBER 16

PROGRAM CHAIRMAN:
Talmadge A. Bowden, Jr., M.D.

FACULTY:
Talmadge A. Bowden, Jr., M.D.
Professor and Chief, Section of Gastraintestinal Surgery and Surgical Endascapy Unit
Medical College of Georgia School of Medicine
Augusta

Kenna S. Given, M.D.
Professor and Chief, Section of Plastic Surgery
Medical College of Georgia Schaal of Medicine
Augusta

Edwin L. Hall, Jr., M.D.
Assistant Professor of Surgery
Medical College of Georgia School of Medicine
Augusta

Vendie H. Hooks, III, M.D.
Assistant Professor of Surgery
Medical College of Georgia School of Medicine
Augusta

C. Lawrence Lutcher, M.D.
Professar and Chief of Hematalagy
Medical College of Geargia School of Medicine
Augusta

Arlie R. Mansberger, Jr., M.D.
Professor and Chairman, Department of Surgery
Medical College of Geargia
Augusta

Robert R. Nesbitt, Jr., M.D.
Professor and Chief of Surgical Services VAMC
Medical College of Georgia School of Medicine
Augusta

Richard C. Treat, M.D.
Assistant Prafessor and Chief Burn/Trauma Service
Medical College of Georgia School af Medicine
Augusta

Roy Witherington, M.D.
Professor and Chief, Section of Urology
Medical College of Georgia School af Medicine
Augusta

SESSION I Hernia, Esophagus, Stomach, Small & Large Intestine, Liver, Biliary Tract, Pancreas, Infectians, Operating Room Technique and Environment.

Talmadge A. Bowden, Jr., M.D.
Vendie H. Hooks, III, M.D.
Robert R. Nesbitt, Jr., M.D.

SESSION II Wounds, Burns, Skin, Plastic and Reconstructive, Trauma, Shock, and Resuscitation.

Richard C. Treat, M.D.
Edward L. Hall, Jr., M.D.
Kenna S. Given, M.D.

SESSION III Fluids and Electrolytes, Metabolism, Surgical Endocrinology, Hematology, and Genitourinary.

Arlie R. Mansberger, Jr., M.D.
Roy Witherington, M.D.
C. Lawrence Lutcher, M.D.

SATURDAY, NOVEMBER 17

PROGRAM CHAIRMAN:
William M. McKinnon, M.D.

FACULTY:

Donald H. Campbell, M.D.
General Surgery
Marietta

John J. Coleman, III, M.D.
Assistant Professor of Surgery
Emory University School of Medicine
Atlanta

Eugene D. Davidson, M.D.
Clinical Assistant Professor of Surgery
Emory University School of Medicine
Atlanta

Peggy G. Duke, M.D.
Clinical Assistant Professor of Anesthesiology
Emory University School of Medicine
Atlanta

J. Timothy Fulenwider, M.D.
Assistant Professor of Surgery
Emory University School of Medicine
Atlanta

Robert A. Guyton, M.D.
Associate Professor of Surgery (Cardio-Thoracic)
Emory University School of Medicine
Atlanta

Richard R. Ricketts, M.D.
Assistant Professor of Surgery (Pediatric)
Emory University School of Medicine
Atlanta

G. Tom Shires, Jr., M.D.
Assistant Professor of Surgery
Emory University School of Medicine
Atlanta

Robert B. Smith, III, M.D.
Professor of Surgery
Chief, Vascular Surgery
Emory University School of Medicine
Atlanta

8:30- 8:35 WELCOME
William M. McKinnon, M.D.

8:35- 9:00 ANESTHESIA
Peggy G. Duke, M.D.

9:00- 9:25 VASCULAR
Robert B. Smith, III, M.D.

9:25- 9:50 CARDIAC-THORACIC
Robert A. Guyton, M.D.

9:50-10:15 QUESTIONS AND ANSWERS
Moderator: Robert B. Smith, III, M.D.

10:15-10:45 COFFEE BREAK

10:45-11:10 IMMUNOLOGY — CANCER
Donald H. Campbell, M.D.

11:10-11:35 INTENSIVE CARE
G. Tom Shires, Jr., M.D.

11:35-12:00 NUTRITION
J. Timothy Fulenwider, M.D.

12:00-12:30 QUESTIONS
Moderator: J. Timothy Fulenwider, M.D.

12:30- 2:00 LUNCH BREAK

2:00- 2:25 PEDIATRIC SURGERY
Richard R. Ricketts, M.D.

2:25- 2:50 HEAD & NECK
John J. Coleman, III, M.D.

2:50- 3:15 BREAST
Eugene D. Davidson, M.D.

3:15- 3:40 QUESTIONS
Moderator: Eugene D. Davidson, M.D.

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TELEPHONE 404/876-7535 OR
TOLL FREE IN GEORGIA 800/282-0224

REGISTRATION FORM

1984 MAG Scientific Assembly

NOVEMBER 16-18, 1984

THE RITZ-CARLTON BUCKHEAD HOTEL, ATLANTA

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Office Address _____

City/State _____ Zip Code _____

IMPORTANT! PLEASE INDICATE THE PROGRAM FOR WHICH YOU WISH TO REGISTER (check one only)

- ☐ Allergy & Immunology
- ☐ Chest Disease
- ☐ Emergency Medicine
- ☐ Gastroenterology
- ☐ Neurology
- ☐ Neurosurgery
- ☐ Otolaryngology/Head & Neck Surgery
- ☐ Pathology
- ☐ Plastic Surgery
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Congressman J. Roy Rowland — A Physician and a Gentleman

I FIRST CAME TO KNOW Congressman J. Roy Rowland well when he entered the House of Representatives of the Georgia General Assembly in 1977 as the new representative from Dublin.

He had not been a member of that body long before his colleagues began to recognize him as a man who knew and understood the issues and who realized where his state and nation were headed. He also quickly won the respect of his fellow members as a man of uncommon integrity and sincerity. He possessed an innate ability to express a point of view effectively without being offensive or disagreeable. By the end of his first term, Roy Rowland was generally recognized as one of Georgia's most outstanding freshman legislators.

During his years of service in the Georgia House, Representative Rowland continued to build on this record, sponsoring such significant legislation as the "right to die" bill and the measure banning the sale of methaqualone and similar drugs in the State of Georgia. However, Dr. Rowland was never a single issue legislator, interested in medical matters only, but was knowledgeable and effective in the passage of many bills of importance to Georgia. He was equally effective in opposing bad legislation. In all of this, he impressed his colleagues by his ability to advocate positions strongly, with obvious knowledge and study of the issues at hand, while maintaining warm friendships with those on opposing sides. It would have been difficult, if not impossible, to find any of the 236 members of the Georgia House and Senate who had anything bad to say about Roy Rowland.

It was inevitable that a man of such superb qualities and high principles would be called to higher office, and in 1982, the people of the Eighth Congressional District elected Dr. Rowland to the U.S. House of Representatives. As a further tribute, he has been returned to a second term without opposition.

Now that he is in Washington as a member of Congress, my relationship to Dr. Rowland is no longer on a day-to-day basis. But all of the information that I have received from his colleagues emphasizes that the premier record he established in the Georgia House continues in Congress. It is nothing short of amazing that, as a freshman Congressman, he has been significantly involved in so many important bills and vital legislative issues.

Despite his successes, Roy Rowland remains the same warm, friendly, modest person that first walked onto the floor of the Georgia House of Representatives. His dedication to his fellow man is undiminished. He is a great credit not only to the medical profession but also to all the people of this state and nation. To sum up Roy Rowland in a phrase, he is, above all else, a gentleman.

We salute him for the sacrifices he has made in pursuit of an unselfish career in public service.

James A. Kaufmann, M.D.
Internist, Atlanta, and
Chairman, MAG Council on Legislation

Enhancement of Cardioplegic Myocardial Protection With Calcium Entry Blockers

ROBERT A. GUYTON, M.D., LYNNE M. DORSEY, B.S.N., ROBERT A. KATES, M.D., and CHARLES R. HATCHER, JR., M.D., *Atlanta**

Introduction

VERY EFFECTIVE METHODS of myocardial preservation during the ischemic arrest interval required for open heart surgery have been developed over the last quarter century. The basic principles of these methods include metabolic preparation of the heart prior to ischemic arrest; cooling of the myocardium by systemic hypothermia, coronary perfusion, and local irrigation; cessation of the electrical and mechanical activity of the heart; and provision of optimal metabolic and hemodynamic conditions for reperfusion. These goals can be partially achieved by manipulation of the hemodynamic, thermal, and chemical milieu during ischemic arrest.[4, 15, 20] In addition to these manipulations, pharmacologic techniques now offer promising opportunities for the enhancement of myocardial preservation. Foremost among the pharmacologic agents are calcium entry blockers.

A Comparison of Four Calcium Entry Blockers

Four calcium entry blockers have undergone extensive evaluation in myocardial preservation: verapamil,[30-32] lidoflazine,[11-13, 19] nifedipine,[2, 6-10, 16, 18, 23, 24, 29, 34, 38] and diltiazem.[1, 36, 37] Although all of these drugs inhibit calcium entry into myocardial and vascular smooth muscle cells, they have different chemical compositions and pharmacologic properties.[21, 22, 26-28] In isolated heart preparations, they all decrease the discharge rate of the sinoatrial node, increase the refractory period of the atrioventricular node, increase A-H conduction time, and decrease myocardial contractility. These drugs also dilate blood vessels by a direct effect on the smooth muscle of systemic and coronary vasculature. However, the relative potencies of each drug for each of these cardiovascular functions are different. For example, nifedipine has potent vasodilatory effects but less marked electrophysiologic effects. This vasodilating effect of nifedipine results in a reflex increase in sympathetic tone such that the net effect is an increase in heart rate, AV conduction, and cardiac output. Verapamil is at the other end of the spectrum. At a dose which causes a relatively small decrease in systemic vascular resistance, its profound electrophysiologic effects cause a decrease in heart rate and A-H conduction and an increase in AV nodal refractory period.[21, 22, 26-28] The differences among these drugs allow one to select the appropriate calcium entry blocker for specific clinical situations.

* From the Carlyle Fraser Heart Center, Crawford W. Long Memorial Hospital, Emory University School of Medicine, Atlanta. This work was supported by grants from the Carlyle Fraser Heart Center, American Heart Association, Georgia Affiliate, and the National Heart, Lung, and Blood Institute, Grant #R01-HL25640-02. Send reprint requests to Dr. Guyton, Carlyle Fraser Heart Center, 25 Prescott St., NE, Atlanta, GA 30308.

Articles for this Page are sponsored and approved by the American Heart Association, Georgia Affiliate. Those wishing to contribute papers to this Page are invited to send them to Dr. Laurence O. Watkins, "Heart Page" Editor, Section of Cardiology, Dept. of Medicine, MCG, Augusta, GA 30909.

The four listed calcium entry blockers are all effective in reducing ischemic myocardial damage. The mechanism of this protection is probably multifactorial. There is a direct correlation between the accumulation of intracellular calcium and the development of mechanical dysfunction, microscopic contracture, and cell death. It has been hypothesized that calcium accumulation *causes* cell damage and that calcium entry blockers delay cell death by preventing this accumulation of calcium. This hypothesis, however, is not supported by several studies which demonstrate that calcium entry blockers are effective only if administered before or simultaneously with the ischemic insult, and that delayed administration is ineffective. Indeed, Nayler has shown that perfusion of guinea pig hearts with a calcium-free perfusate prevented the development of ischemic contracture if such perfusion coincided with the onset of ischemic insult but it did *not* alter the development of contracture if calcium-free perfusion was delayed for 10 minutes after the onset of the ischemic insult.[3, 31] It is possible that intracellular calcium accumulation accelerates cellular destruction, but this has not been proven.

Calcium entry blockers have several hemodynamic effects which may improve myocardial protection during ischemic arrest. As vasodilators, they decrease afterload, which results in a reduction of myocardial oxygen demand.[21, 22, 26-28] At the same time, by virtue of coronary vasodilation they may increase coronary blood flow. Therefore, these drugs improve the metabolic state of the heart prior to arrest and increase high energy phosphate stores. During reperfusion, this same decreased oxygen demand and increased coronary blood flow may help replenish cellular energy stores. All of these beneficial effects, rather than a direct inhibition of calcium influx into damaged myocardial cells, may account for the cardioprotection offered by calcium entry blockers. Nayler et al. demonstrated that pretreatment of rabbit hearts with verapamil or nifedipine led to preservation of myocardial ATP stores and prevention of calcium accumulation during a 90-minute ischemic interval. However, in this same model, pretreatment with propranolol led to the same degree of ATP preservation and prevention of calcium influx.[30] This suggests that metabolic preparation of the heart prior to ischemic arrest may be the primary cardioprotective mechanism of calcium entry blockers.

In addition to the effects of calcium entry blockers in the preservation of cellular integrity, there is some evidence that calcium entry blockade can preserve mechanical function of ischemic myocardial tissue. Calcium entry blockers do increase collateral blood flow to the borders of ischemic regions, but preservation of function also has been shown to occur in regions in which blood flow has not increased.[5, 17, 25, 35]

Specific Calcium Entry Blockers and Ischemic Arrest

Verapamil — Verapamil was the first calcium entry blocker to become available in the United States. Pretreatment with verapamil prior to ischemia has been shown to be effective in protecting guinea pig, rabbit, and rat hearts.[30, 31, 33] The recovery of rat hearts after protection with verapamil was delayed,[33] however, due possibly to a delayed washout of verapamil from the myocardial tissue.[21] The negative dromotropic effect of verapamil may also pose a problem in the clinical utilization of this drug.

Lidoflazine — Pretreatment with lidoflazine has beneficial effects during 1 hour of normothermic ischemic arrest in dogs.[13] These results led to a clinical trial of lidoflazine in over 400 patients in Belgium by Flameng et al. Metabolic recovery of the myocardium (ATP, creatine phosphate, and glycogen) was enhanced in patients by pretreatment with lidoflazine prior to hypothermia and intermittent aortic clamping for aorto-coronary bypass grafting.[12]

Nifedipine — Nifedipine has been extensively studied both as pretreatment prior to ischemia and as a cardioplegic agent during ischemia.[2, 6-10, 18, 23, 24, 29, 34, 38] Nifedipine has beneficial effects on postischemic myocardial function, myocardial stiffness, and mitochondrial calcium accumulation.[2, 7-10, 18, 22] McGovern and colleagues have used a hyperkalemic cardioplegic solution similar to extracellular fluid and have demonstrated that addition of nifedipine preserves myocardial

function and prevents calcium accumulation.[2, 24] Clark reported a clinical trial[6, 7] which demonstrated beneficial effects from nifedipine cardioplegia in high risk patients.

Diltiazem — Diltiazem has been used experimentally as a substitute for hyperkalemia in cardioplegic solutions.[1, 36, 37] It is equivalent and perhaps superior to potassium cardioplegia.[36, 37] The effect of pretreatment with diltiazem has not been studied.

Heterogeneous Cardioplegia

Delivery of cardioplegic solutions in clinical situations is not homogeneous as it often is in the animal laboratory. Coronary stenoses, hypothermia, hemodilution, and the direct effects of cardioplegic solution on coronary arteries may cause maldistribution, which can be detected by intraoperative temperature mapping of the heart. Though simple cardioplegic techniques can effectively protect the heart when the cardioplegic solution can be homogeneously delivered,[11, 16, 19] heterogeneous delivery is an important clinical problem. In our laboratory, we have attempted to test the hypothesis that pretreatment with calcium entry blockers might improve myocardial protection during heterogeneous cardioplegia.[16, 19] We designed a heterogeneous cardioplegia animal model in which the circumflex artery was snared during cardioplegia delivery into the aortic root and released upon reperfusion. This simulates the situation which exists during revascularization in a patient with severe coronary artery disease. A right heart bypass preparation was used for precise control of hemodynamic variables (heart rate, aortic pressure, and cardiac output). Regional myocardial function was determined using sonomicrometry.[11, 16, 19]

Our first experiment with this preparation involved the use of lidoflazine prior to heterogeneous cardioplegia. After 100 minutes of heterogeneous cardioplegic arrest, the control group which did not receive lidoflazine had no significant deterioration of global left ventricular function but a severe deterioration of function in the circumflex region (denied cardioplegia by the circumflex artery snare). The group pretreated with lidoflazine demonstrated preservation of global left ventricular function as well as circumflex regional function. In analyzing regional stiffness in a similar study, we found that changes in compliance or resting length were present in the control group in the well-perfused left anterior descending region and in the non-perfused circumflex region. In the lidoflazine pretreated group, resting muscle length changes were present (although to a lesser degree) in the circumflex region, and there were no stiffness changes in the left anterior descending region.[11] Thus, lidoflazine pretreatment seemed to be beneficial in both the regions of the heart that had good cardioplegia delivery and those regions that had poor cardioplegia delivery.

Our next study compared nifedipine and lidoflazine as protective agents during heterogeneous cardioplegia. We used a 180-minute cardioplegic arrest interval, again snaring the circumflex artery during cardioplegia delivery. In this experiment, the calcium entry blocker was administered prior to ischemia and also added to the cardioplegia solution. Nifedipine had beneficial effects on global ventricular function and regional function, but lidoflazine did not (Figure 1). The hemodynamic effects of these calcium entry blockers could be examined since the pretreatment infusion was given prior to cardioplegic arrest. Lidoflazine in the dose utilized had a profound effect upon systemic vascular resistance and no measurable effect upon left ventricular function or AV node conduction. Nifedipine in the dose utilized had a smaller effect upon systemic vascular resistance and also had no effect upon left ventricular function or AV conduction. Thus nifedipine, in a dose that caused less systemic vasodilation, was superior to lidoflazine in this model.[16]

The use of nifedipine in our experimental study was not without problems. In particular, we found that the extreme light sensitivity of the drug required mixing and infusion under carefully controlled circumstances. Currently, our laboratory is studying the protective effects of diltiazem during heterogeneous cardioplegia

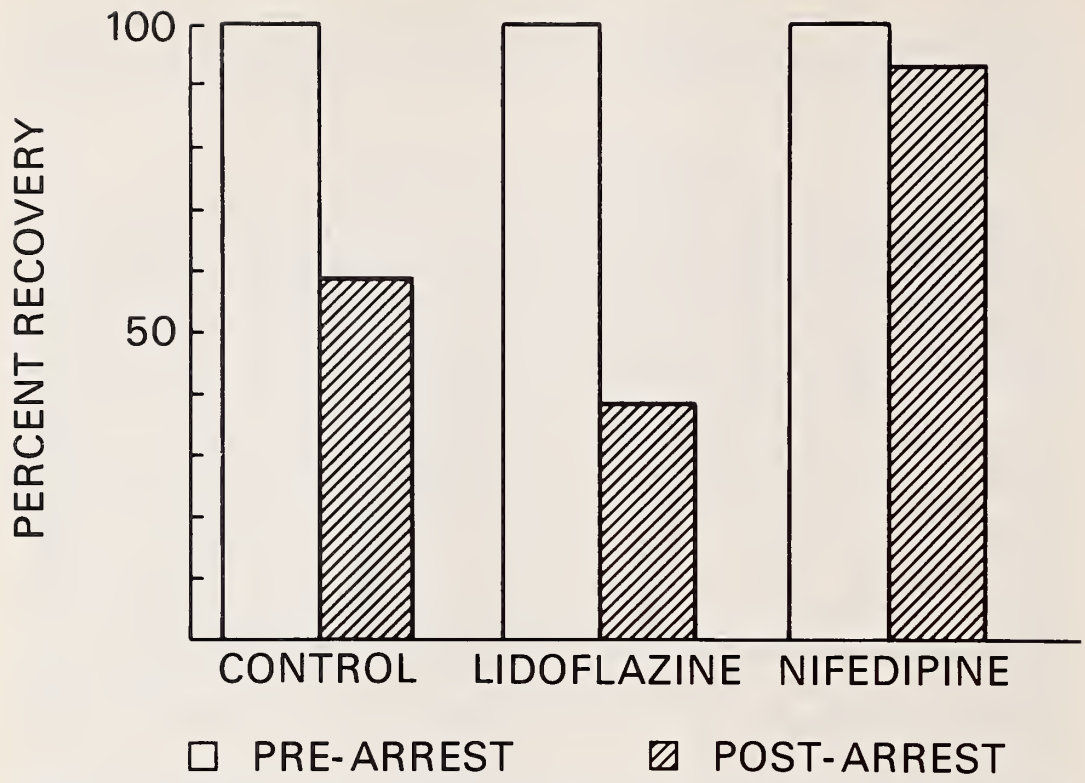


Figure 1 — In groups of animals subjected to 180 minutes of heterogenous cardioplegic arrest, control animals and lidoflazine pretreated animals showed poor recovery of stroke work after the arrest interval. The nifedipine pretreated animals had excellent recovery of stroke work.[16]

infusion. By utilizing all three drugs in a single laboratory, we hope to be able to identify the most appropriate calcium entry blocker for a subsequent clinical trial.

Clinical Implications

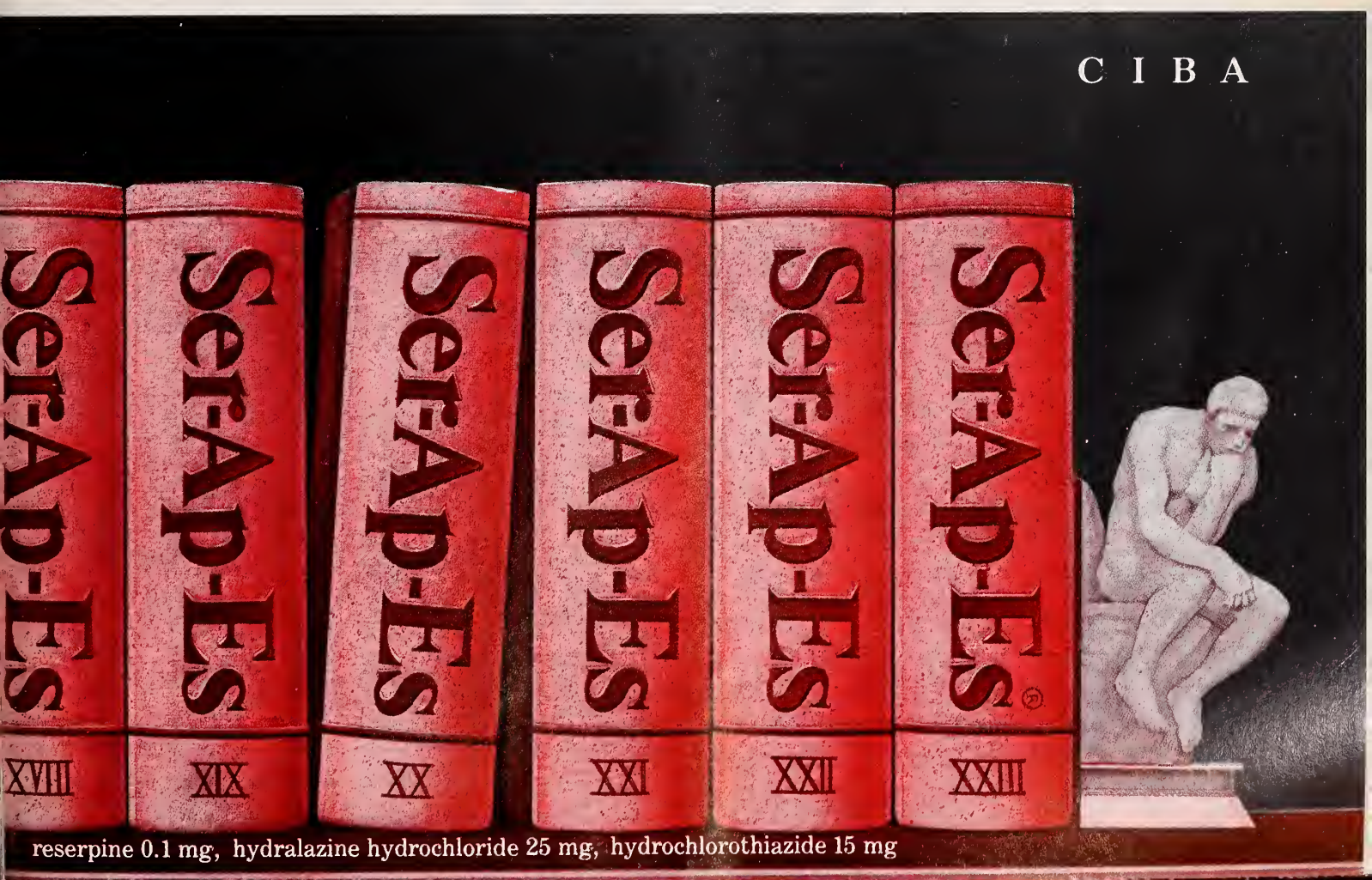
A decade ago, the high incidence of myocardial pump failure in the early postoperative period necessitated the rapid development of myocardial preservative techniques. Current methods of myocardial protection are very successful and, at our institution, pump failure is now a very rare cause of early postoperative mortality. The need for changes in our cardioplegic systems is therefore less urgent but still exists. Delayed loss of myocardial tissue and myocardial fibrosis remain a threat, and our goal is to preserve all viable myocardial tissue.

Based upon laboratory studies, clinical trials of calcium entry blockers as adjuncts to other systems of myocardial preservation seem warranted. These trials must be carefully designed because current clinical results do not justify radical changes in our present techniques.

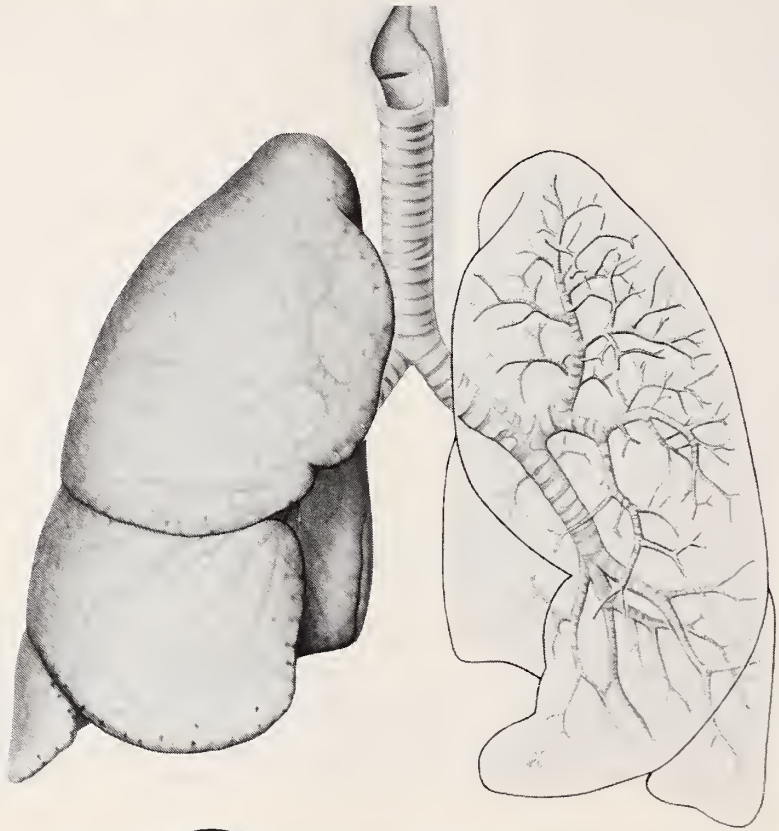
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Indications and Usage: Ceclor* (cefaclor, Lilly) is indicated in the treatment of the following infections when caused by susceptible strains of the designated microorganisms:

Lower respiratory infections, including pneumonia caused by *Streptococcus pneumoniae (Diplococcus pneumoniae), Haemophilus influenzae*, and *S. pyogenes* (group A beta-hemolytic streptococci)

Appropriate culture and susceptibility studies should be performed to determine susceptibility of the causative organism to Ceclor.

Contraindication: Ceclor is contraindicated in patients with known allergy to the cephalosporin group of antibiotics.

Warnings: IN PENICILLIN-SENSITIVE PATIENTS, CEPHALOSPORIN ANTIBIOTICS SHOULD BE ADMINISTERED CAUTIOUSLY THERE IS CLINICAL AND LABORATORY EVIDENCE OF PARTIAL CROSS-ALLERGENICITY OF THE PENICILLINS AND THE CEPHALOSPORINS; AND THERE ARE INSTANCES IN WHICH PATIENTS HAVE HAD REACTIONS, INCLUDING ANAPHYLAXIS, TO BOTH DRUG CLASSES.

Antibiotics, including Ceclor, should be administered cautiously to any patient who has demonstrated some form of allergy, particularly to drugs.

Pseudomembranous colitis has been reported with virtually all broad-spectrum antibiotics (including macrolides, semisynthetic penicillins, and cephalosporins); therefore, it is important to consider its diagnosis in patients who develop diarrhea in association with the use of antibiotics. Such colitis may range in severity from mild to life-threatening.

Treatment with broad-spectrum antibiotics alters the normal flora of the colon and may permit overgrowth of clostridia. Studies indicate that a toxin produced by *Clostridium difficile* is one primary cause of antibiotic-associated colitis.

Mild cases of pseudomembranous colitis usually respond to drug discontinuance alone. In moderate to severe cases, management should include sigmoidoscopy, appropriate bacteriologic studies, and fluid, electrolyte, and protein supplementation. When the colitis does not improve after the drug has been discontinued, or when it is severe, oral vancomycin is the drug of choice for antibiotic-associated pseudomembranous colitis produced by *C. difficile*. Other causes of colitis should be ruled out.

Precautions: *General Precautions* — If an allergic reaction to Ceclor* (cefaclor, Lilly) occurs, the drug should be discontinued, and, if necessary, the patient should be treated with appropriate agents, e.g., pressor amines, antihistamines, or corticosteroids.

Prolonged use of Ceclor may result in the overgrowth of nonsusceptible organisms. Careful observation of the patient is essential. If superinfection occurs during therapy, appropriate measures should be taken.

Positive direct Coombs' tests have been reported during treatment with the cephalosporin antibiotics. In hematologic studies or in transfusion cross-matching procedures when antiglobulin tests are performed on the minor side or in Coombs' testing of newborns whose mothers have received cephalosporin antibiotics before parturition, it should be recognized that a positive Coombs' test may be due to the drug.

Ceclor should be administered with caution in the presence of markedly impaired renal function. Under such conditions, careful clinical observation and laboratory studies should be made because safe dosage may be lower than that usually recommended.

As a result of administration of Ceclor, a false-positive reaction for glucose in the urine may occur. This has been observed with Benedict's and Fehling's solutions and also with Clinitest® tablets but not with Tes-Tape® (Glucose Enzymatic Test Strip, USP, Lilly).

Broad-spectrum antibiotics should be prescribed with caution in individuals with a history of gastrointestinal disease, particularly colitis.

Usage in Pregnancy — Pregnancy Category B — Reproduction studies have been performed in mice and rats at doses up to 12 times the human dose and in ferrets given three times the maximum human dose and have revealed no evidence of impaired fertility or harm to the fetus due to Ceclor* (cefaclor, Lilly). There are, however, no adequate and well-controlled studies in pregnant women. Because animal reproduction studies are not always predictive of human response, this drug should be used during pregnancy only if clearly needed.

Nursing Mothers — Small amounts of Ceclor have been detected in mother's milk following administration of single 500-mg doses. Average levels were 0.18, 0.20, 0.21, and 0.16 mcg/ml at two, three, four, and five hours respectively. Trace amounts were detected at one hour. The effect on nursing infants is not known. Caution should be exercised when Ceclor is administered to a nursing woman.

Usage in Children — Safety and effectiveness of this product for use in infants less than one month of age have not been established.

Adverse Reactions: Adverse effects considered related to therapy with Ceclor are uncommon and are listed below.

Gastrointestinal symptoms occur in about 2.5 percent of patients and include diarrhea (1 in 70).

Symptoms of pseudomembranous colitis may appear either during or after antibiotic treatment. Nausea and vomiting have been reported rarely.

Hypersensitivity reactions have been reported in about 1.5 percent of patients and include morbilliform eruptions (1 in 100). Pruritus, urticaria, and positive Coombs' tests each occur in less than 1 in 200 patients. Cases of serum-sickness-like reactions (erythema multiforme or the above skin manifestations accompanied by arthritis/arthralgia and, frequently, fever) have been reported. These reactions are apparently due to hypersensitivity and have usually occurred during or following a second course of therapy with Ceclor. Such reactions have been reported more frequently in children than in adults. Signs and symptoms usually occur a few days after initiation of therapy and subside within a few days after cessation of therapy. No serious sequelae have been reported. Antihistamines and corticosteroids appear to enhance resolution of the syndrome.

Cases of anaphylaxis have been reported, half of which have occurred in patients with a history of penicillin allergy.

Other effects considered related to therapy included eosinophilia (1 in 50 patients) and genital pruritus or vaginitis (less than 1 in 100 patients).

Causal Relationship Uncertain — Transitory abnormalities in clinical laboratory test results have been reported. Although they were of uncertain etiology, they are listed below to serve as alerting information for the physician.

Hepatic — Slight elevations in SGOT, SGPT, or alkaline phosphatase values (1 in 40).

Hematopoietic — Transient fluctuations in leukocyte count, predominantly lymphocytosis occurring in infants and young children (1 in 40).

Renal — Slight elevations in BUN or serum creatinine (less than 1 in 500) or abnormal urinalysis (less than 1 in 200).

[061782R]

Note: Ceclor* (cefaclor, Lilly) is contraindicated in patients with known allergy to the cephalosporins and should be given cautiously to penicillin-allergic patients.

Penicillin is the usual drug of choice in the treatment and prevention of streptococcal infections, including the prophylaxis of rheumatic fever. See prescribing information.

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400441

Judicial Erosion of the Burden on Plaintiffs to Introduce Expert Testimony in Medical Malpractice Actions

ROBERT N. BERG, *Atlanta**

In Georgia, a physician "must bring to the exercise of his profession a reasonable degree of care and skill," and the failure on the physician's part to comply with this standard may constitute malpractice.[1] At the same time, however, physicians are not insurers, and the fact that a particular medical procedure results in an unfavorable outcome does not by law even raise an inference that the procedure was performed negligently.[2]

Rather, in an action for malpractice, it is *presumed* that the medical or surgical services were rendered in an ordinarily skillful manner, and the burden of proof is on the plaintiff to show a want of due care, skill, and diligence on the part of the physician.[3] Moreover, the question of whether or not the physician exercised the appropriate degree of care and skill is a *medical* question, to be established by *expert testimony*.[4]

Accordingly, a plaintiff seeking to prove that a physician was guilty of malpractice cannot go it alone. Instead, the plaintiff must find an expert witness — a person with the training and experience necessary to provide meaningful testimony on the question of due care in a medical malpractice case — to testify that the defendant physician failed to use the requisite degree of care and skill in treating the patient. Even this may not be enough, however, if the expert witness does no more than testify as to a difference in views of individual practices between the expert and the defendant physician — as long as each view or practice is acceptable, the fact that the defendant physician chose a different view or practice from that which would have been selected by the patient's expert witness is insufficient to show that the defendant physician acted negligently.[5]

Nevertheless, the plaintiff's burden of proof in a medical malpractice case is not insurmountable; Georgia's law on the need for expert testimony in medical malpractice cases does reflect the recognition that it should not be *too* difficult for a plaintiff to satisfy his or her burden of proof. For example, while most states subscribe to the "locality" doctrine — whereby a physician will be judged by the standard of care and skill utilized by physicians in the *locality* in which the particular physician practices — Georgia has long subscribed to a "national" standard, such that a physician will be held to the standard of care and skill practiced by the profession *generally*.[6] This eases the plaintiff's task of finding an expert witness, such as by allowing the patient to introduce expert testimony from a physician practicing in California, despite the fact that the defendant physician rendered services solely in Georgia.

* Prepared at the request of the Medical Association of Georgia. Mr. Berg is an associate in the firm of Powell, Goldstein, Frazer & Murphy, General Counsel to the Association, 1100 C & S National Bank Building, Atlanta, GA 30335.

A second example of the judicial relaxation of the burden of proof imposed on plaintiffs in medical malpractice actions is found with regard to the required qualifications of those persons who may testify, as expert witnesses, on behalf of the patients. Recently, several Georgia cases have dealt with this issue. For example, in *McCormick v. Avert,*[7] the Georgia Supreme Court allowed the patient to introduce the testimony of a nurse, as an "expert" witness, in order to show the proper procedure to be utilized in keeping a hypodermic needle sterile, and thereby to rebut the presumption that the defendant physician used the proper degree of care and skill in drawing a blood sample. Similarly, in *Sandford v. Howard,*[8] the Court of Appeals was faced for the first time with "the question of whether a physician or surgeon of one school of practice is competent to testify as an expert in a malpractice case against a member of another school of practice."[9] The Court resolved this question by holding that, "(w)here there is proof by competent evidence that the methods of treatment are the same despite the difference in the nomenclature of the schools involved, the witness is competent to testify."[10] Thus, the Court allowed several orthopedic surgeons to testify, as experts, as to whether or not the defendant podiatrist had been negligent in treating the plaintiff's flat feet.

Most recently, in *Beatty v. Morgan,*[11] the Court of Appeals was faced with quite an unusual situation. Briefly, the plaintiff patient brought a malpractice action against the defendant urologist, alleging that the defendant negligently failed to diagnose the patient's bladder cancer. In support of his claim, the patient sought to introduce the testimony *of his son,* a licensed physician engaged in the general practice of medicine. The defendant strenuously opposed this attempt, challenging the competency of the physician to serve as an expert witness on the grounds that the physician was engaged in the general practice of medicine, was not a specialist in urology, and, by his own admission, would not have attempted personally to perform the diagnostic and surgical techniques involved in the diagnosis and treatment of bladder cancer and other urologic problems.

Despite the fact that numerous courts in other jurisdictions had accepted this argument,[12] however, the Court declined to do so, finding that:

> The law of this State has not yet reached the point at which a physician testifying as an expert witness on the standard of care exercised by another physician is required to be a specialist in the area of medicine practiced by the other physician. . . . A witness with such skill, knowledge or experience in a field or calling as to be able to draw an inference that could not be drawn by the average layman may be qualified as an expert witness. Medical experts are persons possessing technical and peculiar knowledge, and any person learned in medical or physiological matters is qualified to testify as an expert thereon. . . .[13]

To the Court, the fact that the plaintiff's son was a licensed physician, engaged in the general practice of medicine, whose practice "frequently involves initial diagnosis of urological problems," was sufficient to qualify him as an expert witness. The fact that the physician did not actually treat urologic problems — like the fact that the physician was the patient's son — went to his credibility as an expert witness, rather than to his competency to testify as an expert witness.

Notes

1. O.C.G.A. §51-1-27.
2. See, e.g., *Blount v. Moore,* 159 Ga. App. 80 (1981); *Howell v. Jackson,* 65 Ga. App. 422 (1941).
3. See, e.g., *Stephen W. Brown Radiology Associates v. Gowers,* 157 Ga. App. 770 (1981); *Yeates v. Boyd,* 50 Ga. App. 331 (1935).
4. See, e.g., *Jones v. Wike,* 654 F.2d 1129 (5th Cir. 1981); *Wagner v. Timms,* 158 Ga. App. 538 (1981); *Pilgrim v. Landham,* 63 Ga. App. 451 (1940).
5. See, e.g., *Jackson v. Gershon,* 165 Ga. App. 492 (1983).
6. See, e.g., *Summerour v. Saint Joseph's Infirmary, Inc.,* 160 Ga. App. 187 (1981); compare, *Annotation,* 99 A.L.R.3d 1133 (1980).
7. 246 Ga. 401 (1980).
8. 161 Ga. App. 495 (1981).
9. *Id.,* 161 Ga. App. at 496.
10. *Id.,* 161 Ga. App. at 497.
11. ___ Ga. App. ___ (April 6, 1984).
12. See, generally, *Annotation,* 31 A.L.R.3d 1163 (1970).
13. *Id.,* ___ Ga. App. at ___ (citations omitted).

president's letter



An Anniversary Worth Celebrating

This November, our Association will hold its Tenth Annual Scientific Assembly, and I believe this occasion is something special. In 1974, when the MAG House of Delegates decided to split our Annual Session into two separate meetings, one for business and one for education, we were unsure if the Scientific Assembly would survive. Already specialty societies were emerging as principal providers of medical education, and there were signs that they might prefer to pursue a course independent from MAG.

I'm proud to say that this has not happened. Over the years, despite the rapid growth of all kinds of CME meetings, our Scientific Assembly continues to draw hundreds of physician attendees. The most important reason for our success is the *good relations which MAG enjoys with our state specialty groups*. These ties always need strengthening — this is one of my goals as President this year — and I am proud that the Scientific Assembly provides us an opportunity to work together.

Another reason for our success is the hard work performed by the various program chairmen of the participating societies. In this issue of the *Journal,* you will see the results of their efforts: stimulating, informative, scientific sessions that are tailor-made for the practitioner. For this kind of education, the registration fee we ask is indeed a modest one. Steve Davis, Director of Education for the MAG, has done an outstanding job coordinating this meeting over the years. The facilities for the scientific session this year, at the Ritz-Carlton Buckhead, are excellent. We heard many favorable comments last May when the MAG House of Delegates met there also.

I encourage you to review our Scientific Assembly program for next month's meeting. It is a sure sign that MAG and our specialties are working together to advance the cause of medical education. And that's something to be proud of.

S. William Clark

S. William Clark, Jr., M.D.

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the association
the association

NEW MEMBERS

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Almeroth, Richard D., Barrow—ACT (N-2)—AN
Barrow Medical Center, Box 768, Dept. of Anesthesiology, 1035 N. Broad St., Winder 30680

Anthony, Clement R., Muscogee—I&R
The Medical Center, P.O. Box 951, Columbus 31994-2299

Bacastow, David W., C. W. Long—ACT (N-2)—ORS
1000 Hawthorne Ave., Athens 30610

Balkcom, Ichabod L., Muscogee—I&R—FP
The Medical Center, P. O. Box 951, Columbus 31994-2299

Bromer, Richard H., Richmond—ACT—IM/ON
2101 Central Ave., Augusta 30904

Brooks, A. Patrick, C. W. Long—ACT (N-2)—IM
700 Oglethorpe Ave., Athens 30606

Bullock, Dennis G., Muscogee—I&R—FP
The Medical Center, P. O. Box 951, Columbus 31994-2299

Davis, Diane W., Laurens—I&R—OTO
22 Erin Office Park, Dublin 31021

Deen, Roy W., Bibb—I&R
Medical Center of Central Georgia, Macon 31208

Dorough, Karen L., Bibb—OBG
Medical Center of Central Georgia, Box 54, Macon 31208

Downs, Margaret C., Troup—ACT (N-2)—OBG
303 Medical Drive, LaGrange 30240

Ellis, William W., Thomas Area—ACT (N-1)—CD
114 Mimosa Dr., Thomasville 31792

Emerson, Thomas E., Bibb—I&R
777 Hemlock St., Macon 31208

Fearneyhough, Thomas C., Dougherty—ACT (N-2)—R
P. O. Box 1924, Albany 31703

Foster, Scott C., Muscogee—I&R
The Medical Center, P. O. Box 951, Columbus 31994-2299

Galpin, Robert D., Muscogee—ACT (N-2)—ORS
1920 Warm Springs Rd., Columbus 31995

Gomez, Robert F., C. W. Long—ACT—OTO/A
728 Cobb St., Athens 30606

Graves, Timothy L., Bibb—I&R—FP
784 Spring St., Macon 31201

Guest, William A., Tift—ACT (N-2)—IM/PUD
712 E. 18th St., Tifton 31794

Harris, Gilbert D., C. W. Long—ACT—FP
740 Prince Ave., Athens 30601

Hawasli, M. Hisham, Cobb—ACT—IM/CD
4426 Austell Rd., Austell 30001

Heyboer, Donald J., Laurens—ACT—AN
Fairview Park Hospital, Dublin 31021

Kennedy, Edwin J. G., Muscogee—I&R
The Medical Center, P. O. Box 951, Columbus 31994-2299

Kline, Michael S., Muscogee—I&R
The Medical Center, P. O. Box 951, Columbus 31994-2299

Lamon, James C., Colquitt—ACT—IM
3011 Second St., Moultrie 31768

Patel, Vibhakar R., Floyd-Polk-Chattooga—P/IM
305 W. Fifth St., Rome 30161

Pham, Chuc Van, Bibb—I&R—FP
784 Spring St., Macon 31201

Powers, Edgar B., Gwinnett-Forsyth—ACT—FP
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Proctor, Joseph D., Jr., Camden-Charlton—ACT—IM
421 Osborne St., St. Marys 31558

Pryor, Gary J., Barrow—ACT (N-2)—EM
Emergency Dept., Barrow Medical Center, Winder 30680

Ricketson, John G., Dougherty—ACT (N-2)—OBG
1902 Buck Lane, Albany 31701

Roy, Vance C., Dougherty—ACT—NS
804 Thirteenth Ave., Albany 31701

Sherrer, Jack D., Jr., Muscogee—I&R
The Medical Center, P. O. Box 951, Columbus 31994-2299

Smith, Larry R., Dougherty—ACT (N-2)—A
806 Fourteenth Ave., Ste. 4, Albany 31707

Sprick, Gary L., Bibb—I&R—GS
700 Hemlock St., Macon 31208

(Continued on page 719)

Before prescribing, see complete prescribing information in SK&F CO. literature or *PDR*. The following is a brief summary.

WARNING
This drug is not indicated for initial therapy of edema or hypertension. Edema or hypertension requires therapy titrated to the individual. If this combination represents the dosage so determined, its use may be more convenient in patient management. Treatment of hypertension and edema is not static, but must be reevaluated as conditions in each patient warrant.

Contraindications: Concomitant use with other potassium-sparing agents such as spironolactone or amiloride. Further use in anuria, progressive renal or hepatic dysfunction, hyperkalemia. Pre-existing elevated serum potassium. Hypersensitivity to either component or other sulfonamide-derived drugs.

Warnings: Do not use potassium supplements, dietary or otherwise, unless hypokalemia develops or dietary intake of potassium is markedly impaired. If supplementary potassium is needed, potassium tablets should not be used. Hyperkalemia can occur, and has been associated with cardiac irregularities. It is more likely in the severely ill, with urine volume less than one liter/day, the elderly and diabetics with suspected or confirmed renal insufficiency. Periodically, serum K^+ levels should be determined. If hyperkalemia develops, substitute a thiazide alone, restrict K^+ intake. **Associated widened QRS complex or arrhythmia requires prompt additional therapy.** Thiazides cross the placental barrier and appear in cord blood. Use in pregnancy requires weighing anticipated benefits against possible hazards, including fetal or neonatal jaundice, thrombocytopenia, other adverse reactions seen in adults. Thiazides appear and triamterene may appear in breast milk. If their use is essential, the patient should stop nursing. Adequate information on use in children is not available. Sensitivity reactions may occur in patients with or without a history of allergy or bronchial asthma. Possible exacerbation or activation of systemic lupus erythematosus has been reported with thiazide diuretics.

Precautions: Do periodic serum electrolyte determinations (particularly important in patients vomiting excessively or receiving parenteral fluids, and during concurrent use with amphotericin B or corticosteroids or corticotropin [ACTH]). Periodic BUN and serum creatinine determinations should be made, especially in the elderly, diabetics or those with suspected or confirmed renal insufficiency. Cumulative effects of the drug may develop in patients with impaired renal function. Thiazides should be used with caution in patients with impaired hepatic function. They can precipitate coma in patients with severe liver disease. Observe regularly for possible blood dyscrasias, liver damage, other idiosyncratic reactions. Blood dyscrasias have been reported in patients receiving triamterene, and leukopenia, thrombocytopenia, agranulocytosis, and aplastic and hemolytic anemia have been reported with thiazides. Thiazides may cause manifestation of latent diabetes mellitus. The effects of oral anticoagulants may be decreased when used concurrently with hydrochlorothiazide; dosage adjustments may be necessary. Clinically insignificant reductions in arterial responsiveness to norepinephrine have been reported. Thiazides have also been shown to increase the paralyzing effect of nondepolarizing muscle relaxants such as tubocurarine. Triamterene is a weak folic acid antagonist. Do periodic blood studies in cirrhotics with splenomegaly. Antihypertensive effects may be enhanced in post-sympathectomy patients. Use cautiously in surgical patients. Triamterene has been found in renal stones in association with the other usual calculus components. Therefore, 'Dyazide' should be used with caution in patients with histories of stone formation. A few occurrences of acute renal failure have been reported in patients on 'Dyazide' when treated with indomethacin. Therefore, caution is advised in administering nonsteroidal anti-inflammatory agents with 'Dyazide'. The following may occur: transient elevated BUN or creatinine or both, hyperglycemia and glycosuria (diabetic insulin requirements may be altered), hyperuricemia and gout, digitalis intoxication (in hypokalemia), decreasing alkali reserve with possible metabolic acidosis. 'Dyazide' interferes with fluorescent measurement of quinidine. Hypokalemia is uncommon with 'Dyazide', but should it develop, corrective measures should be taken such as potassium supplementation or increased dietary intake of potassium-rich foods. Corrective measures should be instituted cautiously and serum potassium levels determined. Discontinue corrective measures and 'Dyazide' should laboratory values reveal elevated serum potassium. Chloride deficit may occur as well as dilutional hyponatremia. Concurrent use with chlorpropamide may increase the risk of severe hyponatremia. Serum PBI levels may decrease without signs of thyroid disturbance. Calcium excretion is decreased by thiazides. 'Dyazide' should be withdrawn before conducting tests for parathyroid function.

Thiazides may add to or potentiate the action of other antihypertensive drugs.

Diuretics reduce renal clearance of lithium and increase the risk of lithium toxicity.

Adverse Reactions: Muscle cramps, weakness, dizziness, headache, dry mouth; anaphylaxis, rash, urticaria, photosensitivity, purpura, other dermatological conditions; nausea and vomiting, diarrhea, constipation, other gastrointestinal disturbances; postural hypotension (may be aggravated by alcohol, barbiturates, or narcotics). Necrotizing vasculitis, paresthesias, icterus, pancreatitis, xanthopsia and respiratory distress including pneumonitis and pulmonary edema, transient blurred vision, sialadenitis, and vertigo have occurred with thiazides alone. Triamterene has been found in renal stones in association with other usual calculus components. Rare incidents of acute interstitial nephritis have been reported. Impotence has been reported in a few patients on 'Dyazide', although a causal relationship has not been established.

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The Medical Center, P. O. Box 951, Columbus 31994-2299

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Floyd Medical Center, Turner McCall Blvd., Rome 30161

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The Medical Center, P. O. Box 951, Columbus 31994-2299

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The Medical Center, P. O. Box 951, Columbus 31994-2299

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The Medical Center, P. O. Box 951, Columbus 31994-2299

Witt, Michael A., Whitfield-Murray—ACT (N-2)—FP
Doctors Clinic, Old Dalton-Elijay Hwy., Chatsworth 30705

Zimmerman, Keith W., Muscogee—I&R
The Medical Center, P. O. Box 951, Columbus 31994-2299

Zorn, William A., Muscogee—I&R
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PERSONALS

Fourth District

W. Douglas Skelton, M.D., of Atlanta, has been appointed Assistant Director for Governmental Relations for Emory University's Robert W. Woodruff Health Sciences Center. He will be involved with all aspects of the Health Science Center's relationships with governmental agencies and elected officials.

Dr. Skelton is Professor of Psychiatry at Emory University's School of Medicine. He has served as Commissioner of the Georgia Department of Human Resources, Director of Georgia's Division of Mental Health and Retardation, and as a member of the National Advisory Mental Health Council. He currently serves as Chairman of the State Health Policy Council which oversees health policy development in Georgia.

Fifth District

M. J. Jurkiewicz, M.D., of Sandy Springs, Chief of the Division of Plastic and Reconstructive Surgery at Emory University School of Medicine, has been named the 1984 recipient of the Scientific Achievement Award presented periodically by the AMA in recognition of outstanding work in medicine. Dr. Jurkiewicz is recognized as the surgeon who played a significant role in the development of many of the procedures in which muscle and skin flaps from one part of the body are used to reconstruct defects in another part.

Paul Scheinberg, M.D., has been named medical director of the respiratory therapy department at North Fulton Medical Center hospital.

Eighth District

Brunswick physician, **Eric W. Friedrich, M.D.,** has been named a Fellow of the American Academy of Facial Plastic and Reconstructive Surgery.

DEATHS

Dave Berman

Dave Berman, M.D., 77, died July 19. Dr. Berman graduated from Emory University School of Medicine. He did his internship and residency at Grady Memorial Hospital in Atlanta and postgraduate training at New York Skin and Cancer Hospital in New York City. He was a captain in the Army Medical Corps and spent 2 years in Europe as chief of dermatology, 159th General Hospital. He was past president of the Muscogee County Medical Society, past president of the Third District Medical Society, a Fellow of the American Academy of Dermatology, a member of the Southeastern Dermatological Society, past president of the Georgia Society of Dermatologists, and a member of the Muscogee County Medical Society. Dr. Berman was the first specialist in dermatology in the Columbus area.

Survivors include two daughters and five sisters.

Luther Mack Shealy, Sr.

Luther Mack Shealy, Sr., M.D., of Quitman, died July 19 at age 62. Dr. Shealy was a veteran of World War II and the Korean Conflict. He was a member of the Southern Medical Association, Brooks-Thomas Medical Association, the AMA, Brooks County Board of Health, and chief of staff of the Presbyterian Home.

Dr. Shealy is survived by his wife, one daughter, two sons, two granddaughters, one sister, and one brother.

Physician Recognition Awards — Con't. from p. 720.

Richard L. Sturm, Atlanta
Hubert M. Suber, Vidalia
Beverly A. Taylor, Norcross
Bipin D. Thakrar, Demorest
Donald R. Thomas, Dalton
Alain D. Toland, Martinez
Charles S. Tressler, Hinesville
Carlos R. Triana, Patterson
Marc I. Unterman, Loganville
Rosa C. Urrutia, Smyrna
Gerard P. Verly, Mableton
Charles W. Walden, Tucker
Charles I. Ware, Cornelia
Otis J. Woodard, Albany
Mohammad Zafiruddin, Augusta
Richard Allen Zellmer, Stone Mountain

Physician's Recognition Award Recipients

LISTED BELOW *are those physicians in Georgia who have earned the AMA's Physician's Recognition Award (PRA) from April through June, 1984.*

The Award was established in 1969 "to recognize, encourage, and support physicians who participate regularly in continuing medical education and to emphasize the importance of developing more meaningful continuing medical education opportunities for physicians." A minimum of 150 credit hours of CME must be earned over a 3-year period to qualify for the Award. The hours may include such activities as conferences, residencies, teaching, writing, private reading, listening to cassettes, home study courses, consultation, and peer review; at least 60 of the hours, however, must be from formal CME programs sponsored or co-sponsored for Category I credit by organizations accredited for these activities.

The MAG House of Delegates has set a goal that all MAG members shall have received the PRA by 1985. We congratulate the following physicians who have distinguished themselves and their profession by their commitment to continuing education:

Joseph H. Acevedo, Augusta
Dogan Aktunc, Martinez
Alfredo Alarcon, Atlanta
Rafael A. Alvarez, Milledgeville
Steven M. Amster, Jesup
Roy A. Bakay, Atlanta
Thomas W. Bantly, Decatur
William B. Bates, Waycross
John B. Baxley, Augusta
William R. Beach, Atlanta
Robin R. Bennett, Fort Gordon
Merrill Berman, Austell
Allan Bleich, Atlanta
Gerlad W. Bohanan, Warner Robins
Frank P. Bowyer, Macon
Robert G. Bradbury, Savannah
Allen N. Brown, Augusta
Carson B. Burgstiner, Savannah
Kenneth W. Byers, Calhoun
William J. Casarrella, Atlanta
Charles I. Caulton, Milledgeville
Frank S. Celestino, Columbus
Yung S. Cheng, Savannah
Teresa E. Clark, Atlanta
James A. Classen, Evans
Henry T. Clay, Macon
William W. Coppedge, Atlanta
Charlotte T. Cox, Macon
Allan J. Dinnerstein, Riverdale
John C. Durham, Clarkston
Jack R. Edgens, Rome
Walter L. Erhardt, Albany
James A. Evans, Columbus
Ernest G. Fermanis, Atlanta
Donald J. Filip, Atlanta
Robert M. Fine, Decatur
Stephan H. Fromm, Dalton
Robert A. Gadlage, Decatur
Jane Elizabeth Gates, Tybee Island
Gregory L. Fay, Augusta
H. Fred Gober, Atlanta
Gordon T. Goldstein, East Point
Julian R. Gomez, Atlanta
Samuel M. Goodrich, Milledgeville
Woodrow Goss, Ashburn
William E. Gray, Statesboro
Joe L. Griffith, Commerce
Charles C. Gullett, Atlanta
Pradip Gupta, Dublin
Hamid A. Hadi, Augusta
David Haim, Columbus
Dewey Hammond, Fairmont
William J. Hammond, Fitzgerald
John H. Harbour, Smyrna
Katrine R. Hawkins, Sylvania
Charles G. Helmick, Atlanta
Louis J. Herskowitz, Dunwoody
William F. Hogan, Thomasville
Emory W. Holloway, Macon
Gerald B. Holzman, Augusta
D. Robert Howard, Macon
Peter Hydrick, East Point
Floyd James, Dalton
Walter M. Jay, Augusta
George R. Jones, Tucker
Rafik B. Kashlan, Riverdale
David B. Kee, Decatur
George C. King, Clayton
Gilbert S. Klemann, Albany
Alex Z. Klopman, Roswell
Veeni S. Kumar, Douglasville
John D. Lenton, Tucker
Jeffrey B. Lichtman, Atlanta
Ernesto G. Lopez, Waycross
Gary Z. Lotner, Atlanta
Wallace Lucas, Cochran
Philip F. Macon, Atlanta
George E. Malcom, Roswell
Marvin L. Marchman, Norcross
James E. Marlow, Dalton
Duncan R. Marsh, Albany
Bolivar P. Martineau, College Park
Sandra B. McCann, Columbus
Ramon V. Meguiar, Jesup
Wayne F. Middendorf, Athens
Jonathan A. Mines, Atlanta
Dorothy M. Mitchell, Atlanta
Park R. Mitchell, Marietta
Albert J. Mokal, Atlanta
Christian R. Moorhead, Atlanta
Marcelo Mora, Americus
Susan E. Mumper, Martinez
Elmer A. Musarra, Marietta
Vicente A. Negrin, Augusta
Ethel M. Nelson, Wildwood
Lars R. Newsome, Decatur
Camran Nezhat, Atlanta
Thomas B. O'Barr, Atlanta
Katherine A. O'Hanlan, Atlanta
Herman K. Orlet, Martinez
Dennis E. Ose, Savannah
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Gary A. Passons, Columbus
Arvind M. Patel, Douglas
B. Alfred Pihl, Atlanta
Irvin E. Plank, Resaca
Charles E. Pollock, Washington
J. Maria Porquez, Monroe
Jerome F. Potts, Fort Benning
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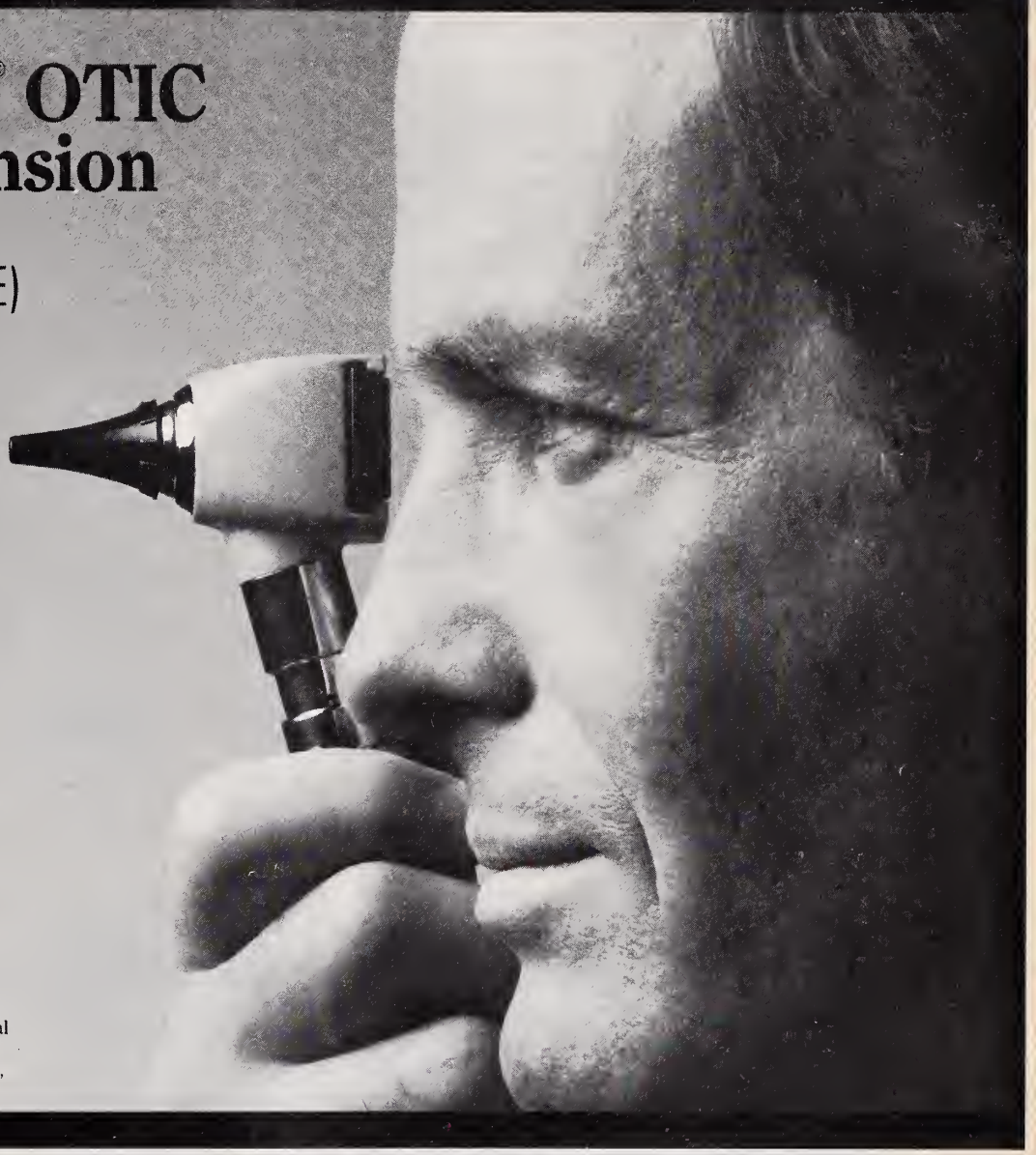
(Continued on p. 719)

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"In 159 of 163 clinically evaluated patients, the otic preparation (solution or suspension) was rated clinically effective, giving a clinical effectiveness for *acute diffuse external otitis* of *97.5%*."[1] (Emphasis added.)

EFFICACY RATES FOR OTIC SUSPENSION AND OTIC SOLUTION (COMBINED RESULTS FROM 4-CENTER STUDY)

	Clinical Efficacy
Suspension	
Total ears	93
Responders	91 (97.8%)
Solution	
Total ears	107
Responders	104 (97.2%)
Combined suspension and solution	
Total ears	200
Responders	195 (97.5%)

Adapted from Cassisi et al.[1]

REFERENCE:
1. Cassisi N, Cohn A, Davidson T, et al: Diffuse otitis externa: Clinical and microbiologic findings in the course of a multicenter study on a new otic solution. *Ann Otol Rhinol Laryngol* 86(suppl 39, pt 3):1-16, 1977.

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Vehicle contains the inactive ingredients cetyl alcohol, propylene glycol, polysorbate 80, water for injection and thimerosal (preservative) 0.01%.
Actions: For the treatment of superficial bacterial infections of the external auditory canal caused by organisms susceptible to the action of the antibiotics.
For the treatment of infections of mastoidectomy and fenestration cavities caused by organisms susceptible to the antibiotics.
Precautions: This drug should be used with care in cases of perforated eardrum and long-standing cases of chronic otitis media because of the possibility of ototoxicity caused by neomycin.

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Action: Each cc contains:
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Precautions: This drug should be used with care when the integrity of the tympanic membrane is in question because of the possibility of ototoxicity caused by neomycin.
Adverse Reactions: Stinging and burning have been reported when this drug has gained access to the middle ear.

Indications, Warnings, Precautions and Adverse Reactions Common to Both

Indications: These products are contraindicated in those individuals who have shown hypersensitivity to any of the components, and in herpes simplex, vaccinia and varicella.

Warnings: As with other antibiotic preparations, prolonged treatment may result in overgrowth of nonsusceptible organisms and fungi. If the infection is not improved after one week, cultures and susceptibility tests should be repeated to verify the identity of the organism and to determine whether therapy should be changed.

When using neomycin-containing products to control secondary infection in the chronic dermatoses, such as chronic otitis externa, it should be borne in mind that the skin in these conditions is more liable than is normal skin to become sensitized to many substances, including neomycin. The manifestation of sensitization to neomycin is usually a low grade reddening with swelling, dry scaling and itching; it may be manifest simply as a failure to heal. During long-term use of neomycin-containing products, periodic examination for such signs is advisable and the patient should be told to discontinue the product if they are observed. These symptoms regress quickly on withdrawing the medication. Neomycin-containing applications should be avoided for that patient thereafter.

Precautions: If sensitization or irritation occurs, medication should be discontinued promptly. Patients who prefer to warm the medication before using should be cautioned against heating the solution above body temperature, in order to avoid loss of potency.

Treatment should not be continued for longer than ten days. Allergic cross-reactions may occur which could prevent the use of any or all of the following antibiotics for the treatment of future infections: kanamycin, paromomycin, streptomycin, and possibly gentamicin.

Adverse Reactions: Neomycin is a not uncommon cutaneous sensitizer. There are articles in the current literature that indicate an increase in the prevalence of persons sensitive to neomycin.

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Committee Activities . . .

Highlights — MAG Executive Committee Meeting

The regular monthly meeting of the Executive Committee (EC) of the Medical Association of Georgia was called to order at 9:00 am on August 12 at MAG Headquarters. Following are highlights of that meeting.

Medical Aspects of Sports Committee — This committee considered 2 resolutions referred to it at the June meeting of the Board of Directors: (1) Resolution on Athletic Injuries and (2) Resolution on Safety on Horseback. The EC approved the recommendations of the Committee. The EC also approved the Committee recommendation's regarding the State Boxing Commission. (Contact the MAG Headquarters if details of these recommendations are needed.)

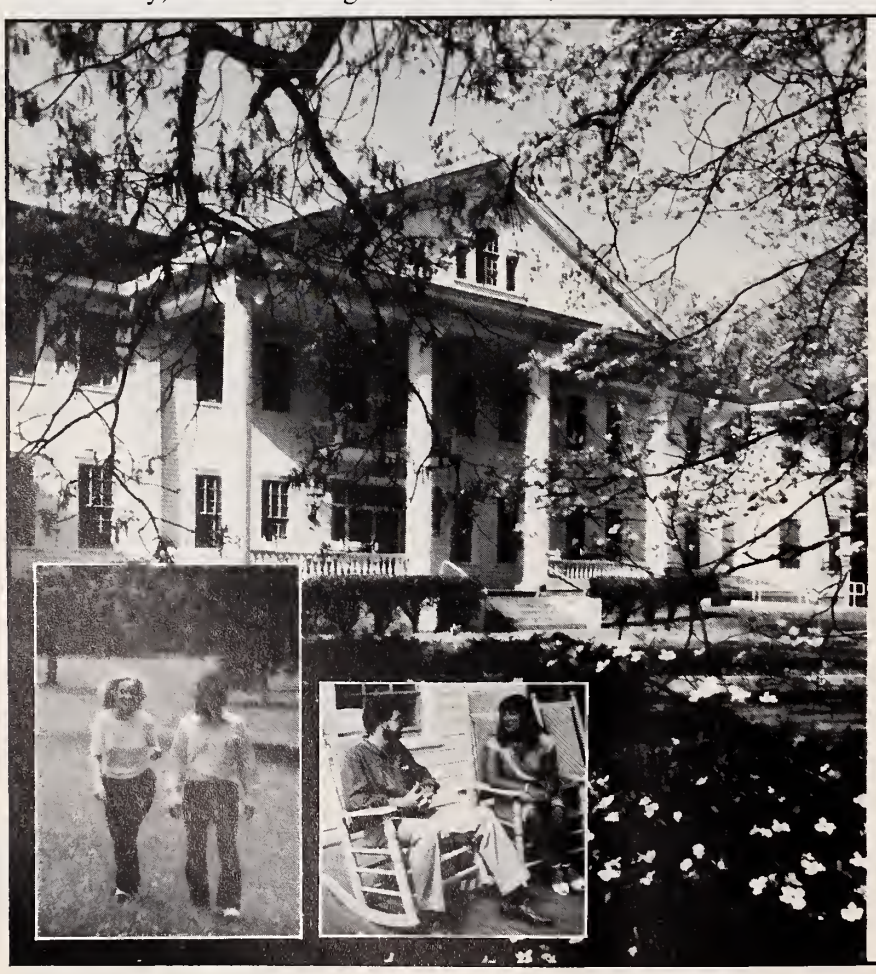
MAG Mutual — An update was given, stressing MAG Mutual's concern regarding Risk Management Seminars and informing the EC that its staff are expert in this field. MAG Mutual felt that they could do more to help MAG membership in these activities and offered staff help and financial assistance. Following discussion, the EC voted to not use any attorney in the Risk Management workshops that excluded the representation of the insured of MAG Mutual.

Resident Physician Section Update — MAG's plans for a Resident Physician Section will be implemented in the near future. Various mechanisms were being explored to implement this program, i.e., computerized data to identify residents; letters to county medical societies to enlist their support and seek their involvement; MAG meetings; Pre-Practice Seminar and Medical Fair; Scientific Assembly; Practice Management Seminars; etc. Following discussion, the EC voted to support one resident physician from each represented organized Resident Physician Group in the State to attend the 1985 MAG House of Delegates meeting in Savannah.

In another action, the EC voted to allocate up to $1500 for one Resident Physician to attend the AMA Interim Meeting in Hawaii.

Amicus Curiae Brief (Georgia Supreme Court Request) — At its July meeting, the EC was requested to submit to the Georgia Supreme Court an Amicus Curiae brief regarding support systems being removed from infants in chronic vegetative states that have complete absence of cognitive functions. At that time, the EC referred the matter to legal counsel to prepare such a brief. The brief was now complete and counsel requested direction from the EC as to the best way to proceed. It was the feeling of the EC that the whole decision should be between the physician and the guardian or next in charge, and expansion upon this decision would be to seek a second opinion. The EC felt that a formal procedure for the decision of removing life support systems was not recommended and the chair requested legal counsel to proceed along these lines.

President's Cabinet — Dr. Clark informed the EC that the first President's Cabinet meeting was held at MAG on August 11, at which time the Council Chairmen gave reports of each individual Council. On motion, the EC established a Deans Committee under the auspices of the Council on Education. This committee will consist of the Deans of the four medical schools in Georgia.



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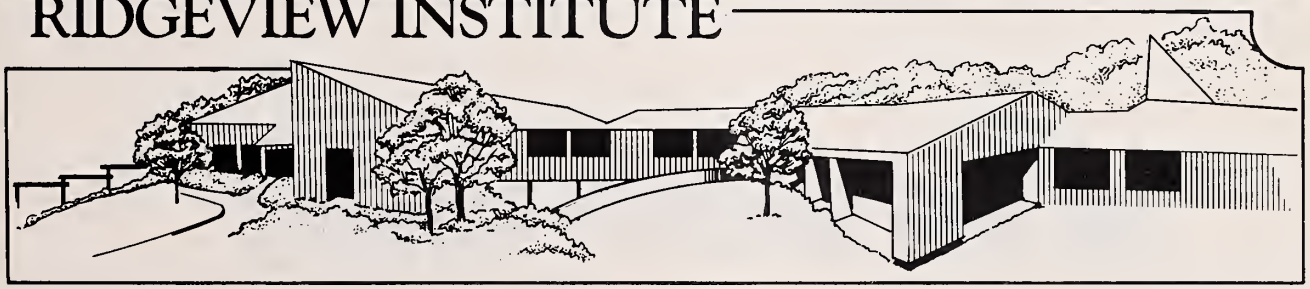
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> Soter NA, Wasserman SI, Austen KF. Cold urticaria release into circulation of histamine and eosinophil chemotactic factor of anaphylaxis during cold challenge. N Engl J Med 1976;294:687-90.

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References: **1.** Kales J *et al. Clin Pharmacol Ther 12*:691-697, Jul-Aug 1971. **2.** Kales A *et al. Clin Pharmacol Ther 18*:356-363, Sep 1975. **3.** Kales A *et al: Clin Pharmacol Ther 19*:576-583, May 1976. **4.** Kales A *et al. Clin Pharmacol Ther 32*:781-788, Dec 1982. **5.** Frost JD Jr, DeLucchi MR: *J Am Genatr Soc 27*:541-546, Dec 1979. **6.** Kales A, Kales JD: *J Clin Pharmacol 3*:140-150, Apr 1983. **7.** Greenblatt DJ, Allen MD, Shader RI: *Clin Pharmacol Ther 21*:355-361, Mar 1977. **8.** Zimmerman AM. *Curr Ther Res 13*:18-22, Jan 1971. **9.** Amrein R *et al: Drugs Exp Clin Res* 9(1):85-99, 1983. **10.** Monti JM: *Methods Find Exp Clin Pharmacol 3*:303-326, May 1981. **11.** Greenblatt DJ *et al: Sleep 5*(Suppl 1):S18-S27, 1982. **12.** Kales A *et al. Pharmacology 26*:121-137, 1983.

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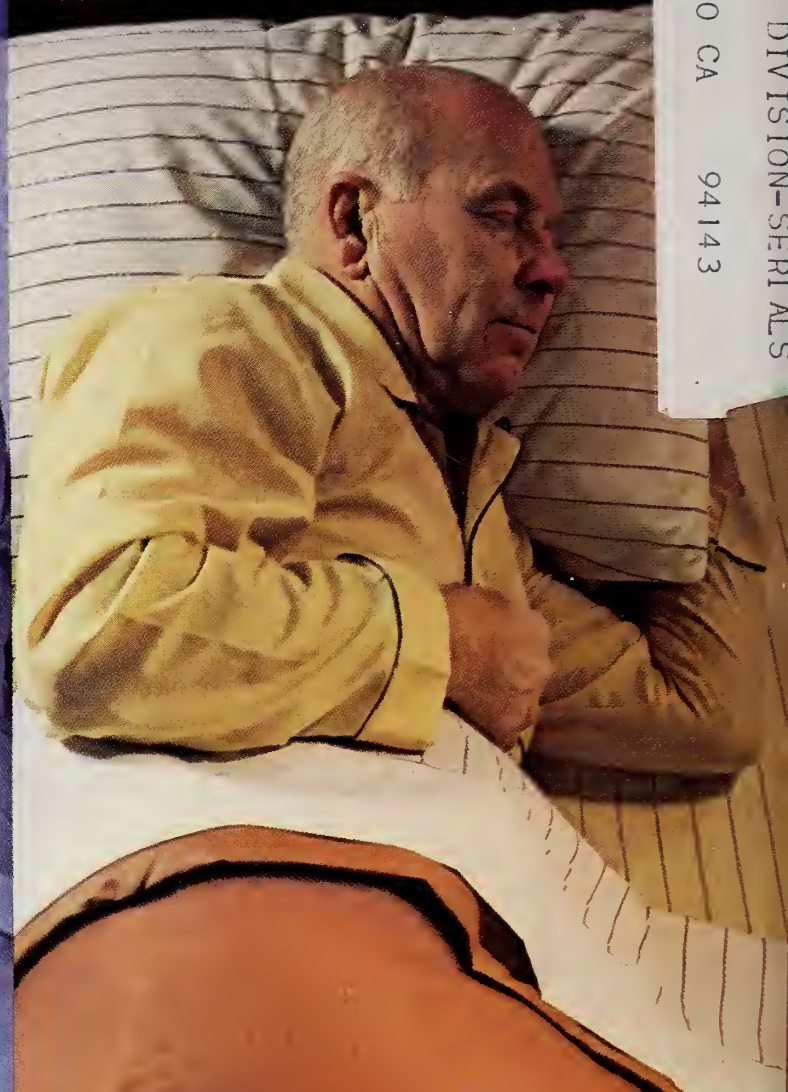
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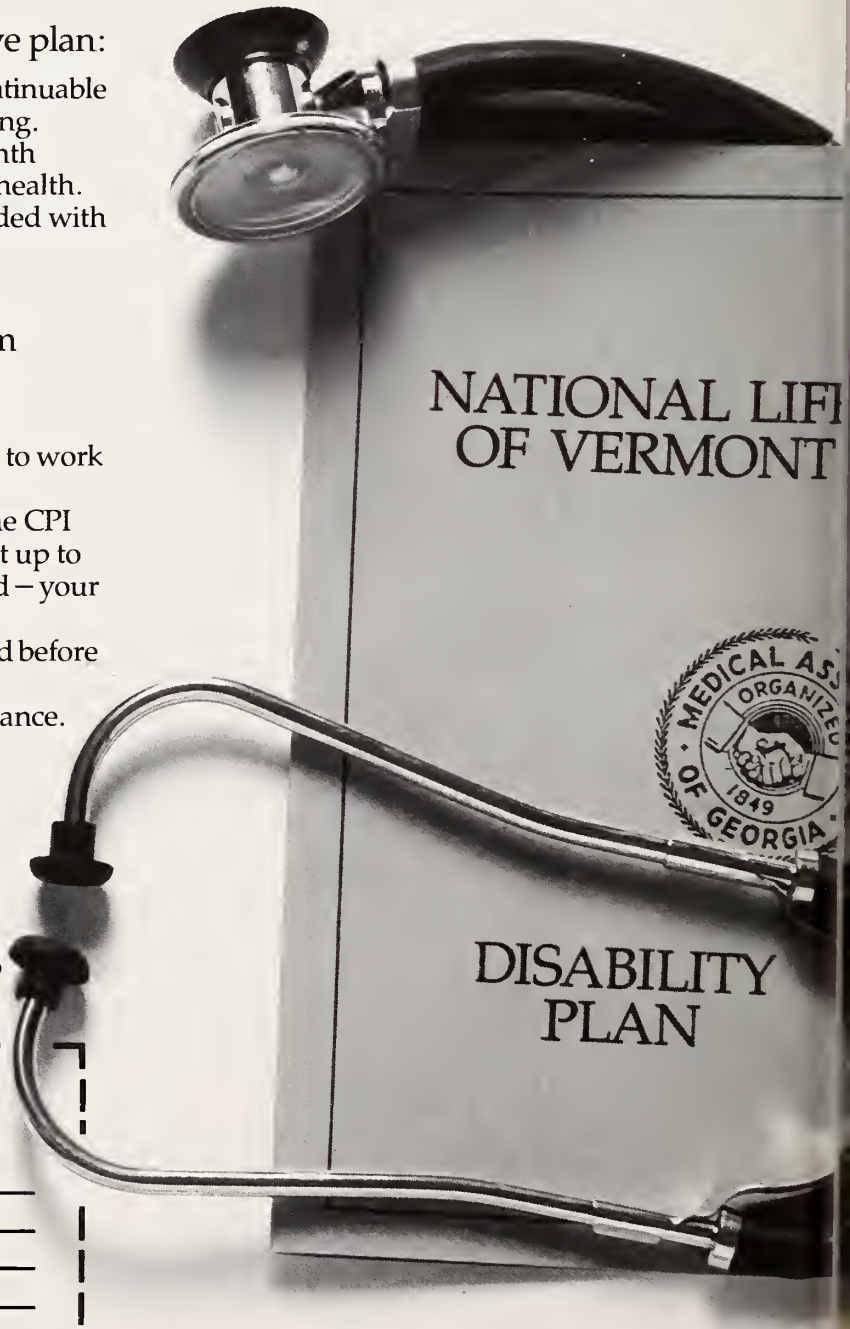
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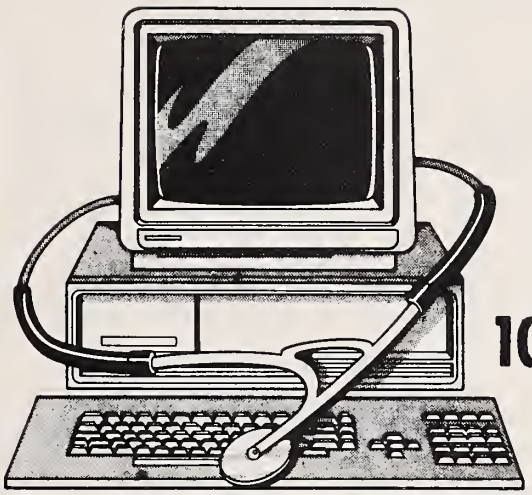


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Established 1911. Owned and edited by the Medical Association of Georgia. Published monthly under the direction of the Board of Directors of the Association. Printed by The Ovid Bell Press, Inc., Fulton, Missouri.

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The subscription price per year for members of the Medical Association of Georgia is $7.50, included in the annual membership dues. The subscription price for nonmembers is $15.00 in the United States, Canada and Mexico, and $17.00 in other countries. Single copies are $2.

The *Journal of the Medical Association of Georgia* is published monthly at 938 Peachtree Street, N. E., Atlanta, GA 30309-3990. Second-class postage paid at Atlanta, Georgia, and at additional mailing offices. POSTMASTER: Send address changes to Medical Association of Georgia, 938 Peachtree Street, N. E., Atlanta, GA 30309-3990.

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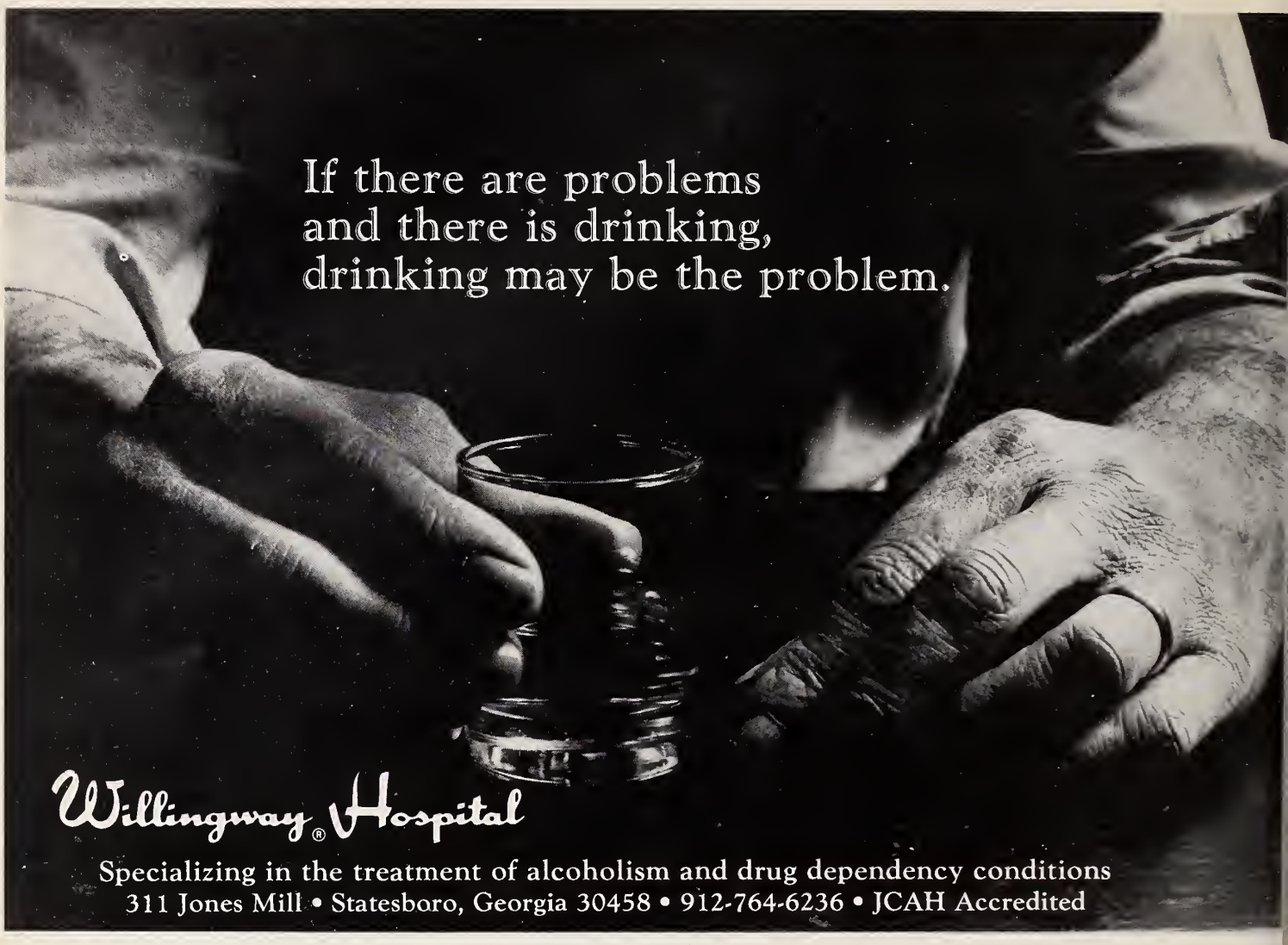
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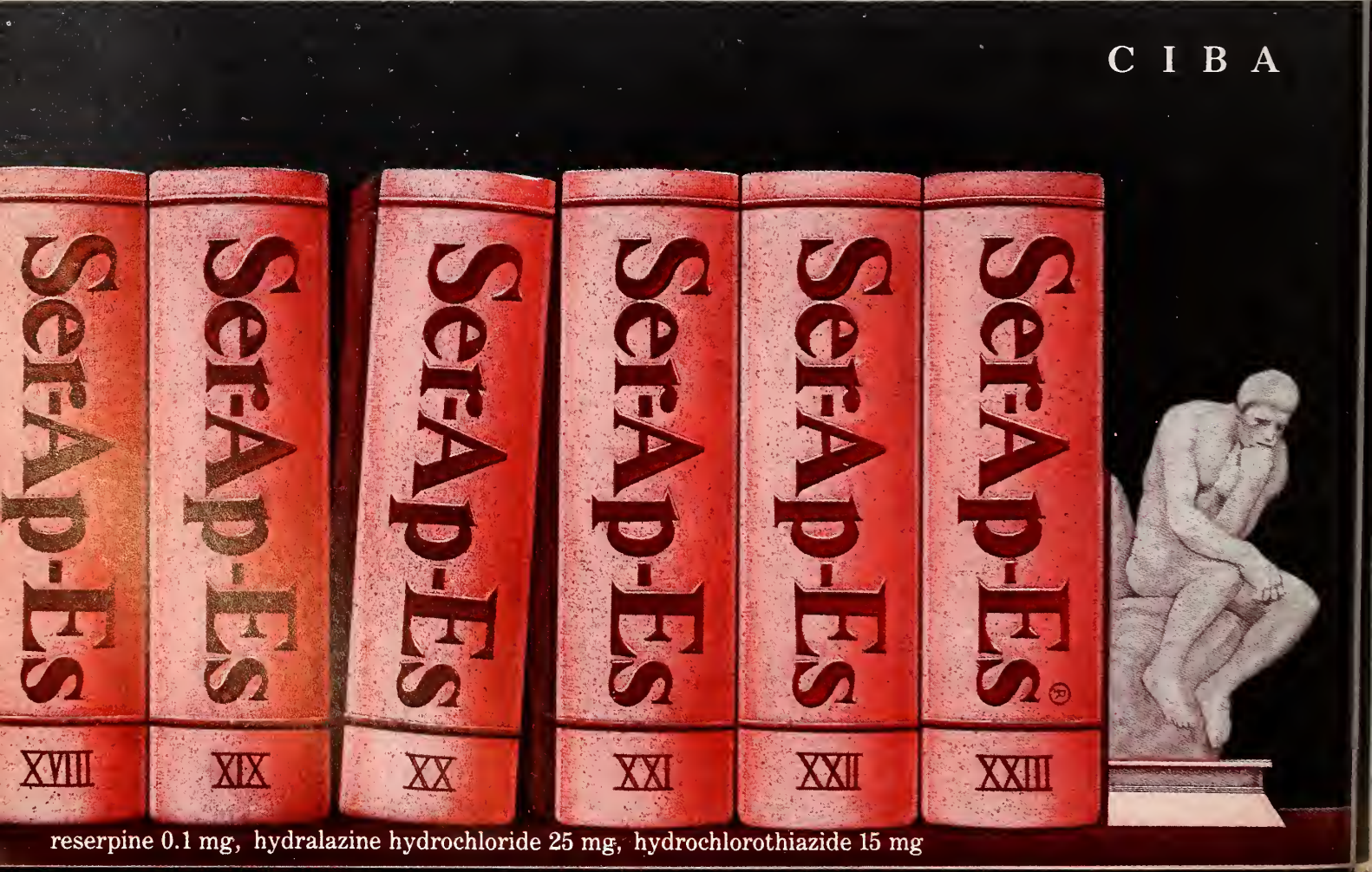
THE COVER

The Caduceus on the cover, with its cracked wings and staff, is the symbol of MAG's Impaired Physicians Program (IPP). The Program Director, G. Douglas Talbott, M.D., is Guest Editor of this special issue which presents a 10-year review of the Program and focuses on special issues confronting physicians with alcoholism and addiction to other drugs.

Photograph by Chuck Rogers, Jr., of Atlanta.



CIBA



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MEDICAL MEETING CALENDAR

NOVEMBER

15-18 — *Atlanta:* **Georgia Academy of Family Physicians' Annual Meeting,** Category 1 and AAFP prescribed credit. Contact Camille Day, Exec. Vice-Pres., GAFP, 11 Corporate Sq., Ste. 205, Atlanta 30329. PH:404/321-7445.

16-18 — *Atlanta:* **MAG Scientific Assembly.** Category 1 credit. Contact Stephen Davis, Dir. of Ed., MAG, 938 Peachtree St., N.E., Atlanta 30309. PH:404/876-7535 or 1-800-282-0224 (toll free in Ga.).

28-Dec. 2 — *Atlanta:* **Ninth Southeastern Conference on Alcohol and Drug Abuse.** Contact Barbara Turner, Charter Med. Corp., Addictive Disease Div., 5780 Peachtree-Dunwoody Rd., N.E., #170, Atlanta 30342.

DECEMBER

1-2 — *Atlanta:* **Regional Anesthesia: Surgery, Obstetrics, and Pain.** Category 1 credit. Contact Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., NE, Ste. 110, Atlanta 30322. PH:404/329-5695.

3-7 — *Atlanta:* **MKSAP VI Review Course.** Category 1 credit. Contact Registrar, Amer. Coll. of Phy., 4200 Pine St., Philadelphia, PA 19104. PH:800/523-1546.

6-9 — *Atlanta:* **From Head to Toes: A Practical Approach to Orthopaedics for the Primary Care Physician.** Category 1 credit. Contact Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., NE, Ste. 110, Atlanta 30322. PH:404/329-5695.

FEBRUARY

1-2 — *Atlanta:* **Medical Association of Georgia Leadership Conference.** Contact MAG, 938 Peachtree St., N.E., Atlanta 30309. PH:404/876-7535 or 1-800-282-0224 (toll free in Ga.).

4-8 — *Puerto Vallarta, Mexico:* **Ninth Annual Conference on Pain.** Category 1 credit. Contact Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., NE, Ste. 110, Atlanta 30322. PH:404/329-5695.

6-10 — *Puerto Vallerta, Mexico:* **Scottish Rite 7th Annual Pediatric Postgraduate Course.** Category 1 credit. Contact Judson Hawk, MD, Dir. of Ped. Ed., Scottish Rite Children's Hosp., 1001 Johnson Ferry Rd., Atlanta 30363. PH:404/257-2040.

7-10 — *Atlanta:* **Georgia Psychiatric Association Winter Meeting.** Category 1 credit. Contact S. Reaves Lee, MD, 1493 LaVista Road, NE, Atlanta 30324. PH:404/321-5259.

18-22 — *Park City, Utah:* **Third Annual Winter Urology Seminar.** Category 1 credit. Contact Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., NE, Ste. 110, Atlanta 30322. PH:404/329-5695.

18-23 — *Augusta:* **Family Practice Symposium.** Category 1 credit. Contact Div. of Cont. Ed., MCG, Augusta 30912. PH:404/828-3967.

MARCH

11-15 — *Park City, Utah:* **Orthopaedics Course.** Category 1 credit. Contact Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., NE, Ste. 110, Atlanta 30322. PH:404/329-5695.

18-22 — *Park City, Utah:* **Orthopaedics Course.** Category 1 credit. Contact Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., NE, Ste. 110, Atlanta 30322. PH:404/329-5695.

APRIL

11-13 — *Atlanta:* **Introduction Into Percutaneous Transluminal Angioplasty V.** Category 1 credit. Contact Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., NE, Ste. 110, Atlanta 30322. PH:404/329-5695.

14-18 — *Atlanta:* **Demonstrations in Percutaneous Transluminal Angioplasty XIII.** Category 1 credit. Contact Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., NE, Ste. 110, Atlanta 30322. PH:404/329-5695.

25-27 — *Atlanta:* **Practical Applications of Computers in Health Care: The Integration of Clinical and Administration Information.** Category 1 credit. Contact Office of CME, Emory Univ. of Sch. of Med., 1440 Clifton Rd., NE, Ste. 110, Atlanta 30322. PH:404/329-5695.

25-28 — *Savannah:* **MAG House of Delegates.** Contact MAG, 938 Peachtree Street, NE, Atlanta 30309. PH:404/876-7535 or 1-800-282-0224 (toll free in Ga.).

28-May 1 — *Atlanta:* **Magnetic Resonance Imaging.** Category 1 credit. Contact Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., NE, Ste. 110, Atlanta 30322. PH:404/329-5695.

29-May 5 — *Augusta:* **Family Practice Symposium.** Category 1 credit. Contact Div. of Cont. Ed., MCG, Augusta 30912. PH:404/828-3967.

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9-12 — *Amelia Island, Fla.:* **Georgia Radiological Society Annual Meeting.** Category 1 credit. Contact Lloyd B. Schnuck, Jr., M.D., 9 Medical Arts Ctr., Savannah 31405. PH:912/355-3642.

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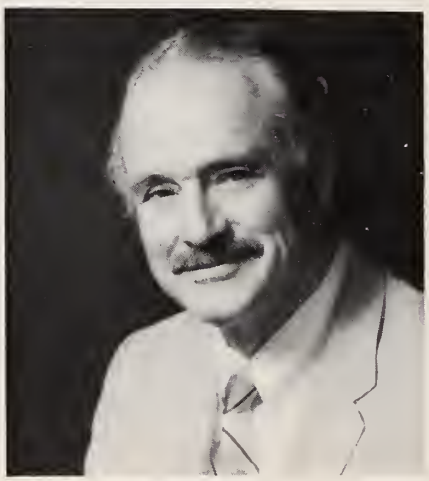
14-16 — *Hilton Head, SC:* **Georgia Society of Dermatologists Annual Meeting.** Category 1 credit. Contact Gerald Chotiner, MD, 3250 Howell Mill Rd., Atlanta 30327. PH:404/352-1730.

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editorial
editorial
editorial

Recovering Impaired Physicians and The Ripple Effect



Dr. Talbott

The Medical Association of Georgia's Impaired Physicians Program has assumed a national leadership role. It continues to be a primary model that this country, Canada, and other nations are looking to for the solution to one of medicine's most consequential problems.

The foundation of the success of this Program has been the commitment of the Medical Association of Georgia to be "thy brother's keeper" within the context of practicing quality controlled medicine for the benefit of the patients and public of Georgia. Fundamental to the growth and success of this Program has been the dedication and support of MAG's Executive Committees and Boards of Directors since 1975. We are also grateful to the MAG *Journal* staff for their cooperation and support in devoting this issue to the Impaired Physicians Program and the disease of chemical dependence.

The Georgia Program's success has evolved because of its unique and salient features which are outlined in the articles by Drs. Gallegos, Norton, Martin, and myself in this special issue of the *Journal*. The two fundamental principles of this program which distinguish it from the counterfeit programs that "mimic for money" are the peer treatment ambience, where doctors are treated with other doctors, and the expert direction of the program with seasoned, expertly trained physicians directing all phases.

As the recovering physician returns to the community, the influence of his recovery begins to ripple, for the physician is both the model and the modeler for his community.

Both excitement and satisfaction are derived from seeing the more than 600 physicians in the Georgia Program progressing in their recovery from this disease. There is exquisite reward in seeing families made whole again. The professional rewards to recovering physicians, their families, and patient communities are

obvious. In many ways, the most exciting product of this program which produces the happy, healthy, and effectively functioning physician is the "ripple effect."

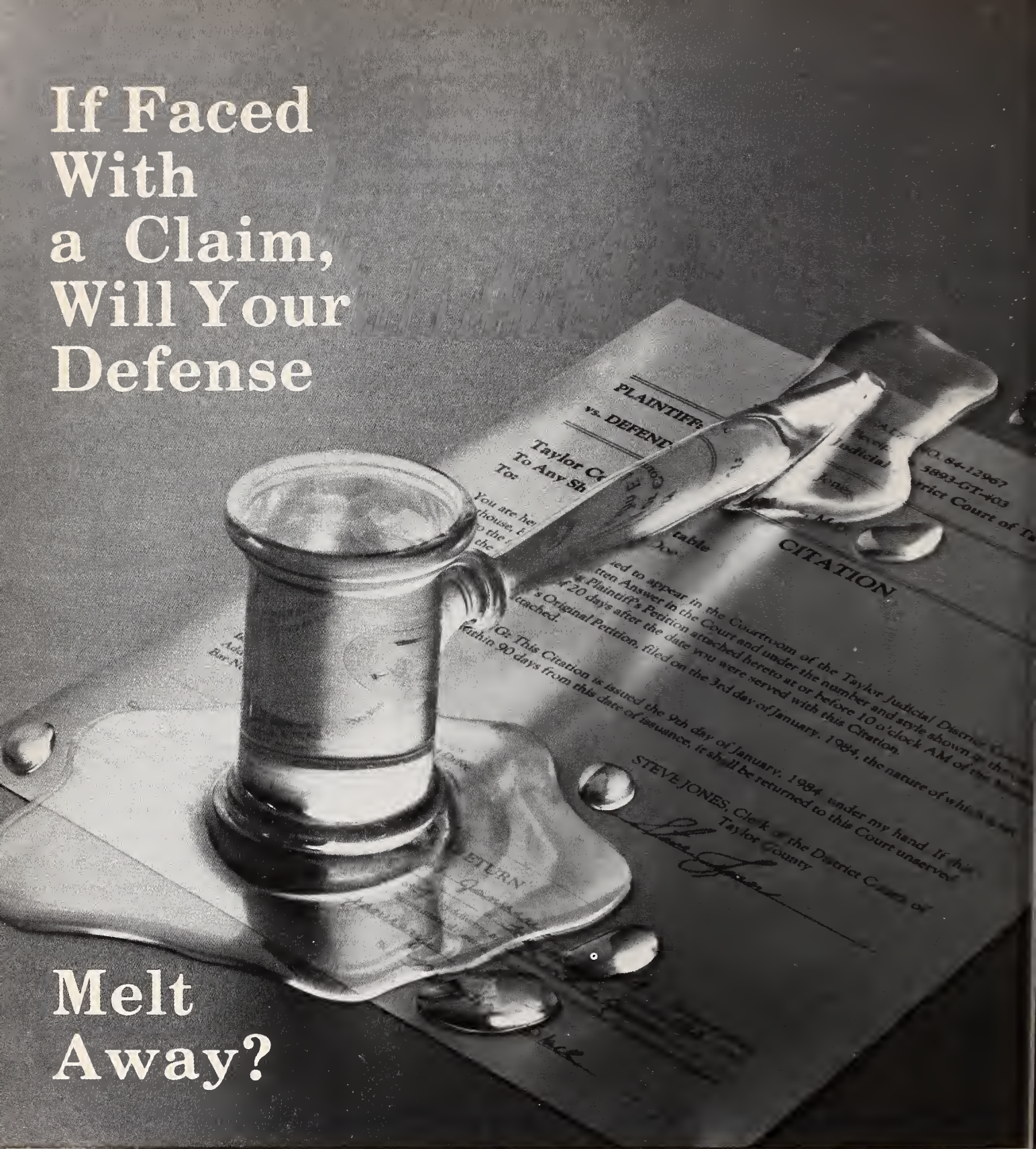
Once the recovering physician returns to his or her community, a "ripple effect" occurs. By that I mean, as the recovering physician returns to the community, the influence of his recovery begins to ripple, for the physician is both the model and the modeler of that community. Good health habits, such as stopping smoking, engaging in aerobics and jogging, abstaining from drinking or drug taking, and getting regular checkups are strengthened. School boards and PTAs have been influenced and community health fairs started by recovering physicians. These are but a sample of this "ripple effect." A specific example of the "ripple effect" is seen in the article by Dr. Edward J. Waits, on page 779 in this issue. This article illustrates his personal involvement with health issues in the hospital where he practices and his cooperation with his colleagues to promote better health habits.

Physicians are a critical part of the nidus and core of that leadership that will do such things as teach the new generation that there are alternatives to instant chemical relief and that it is OK to say no to drugs and alcohol.

If the headlong gallop of America into the chemical culture is to be stemmed, then the medical profession must take the leadership — leadership that will do such things as teach the new generation that there are alternatives to instant chemical relief and that it is OK to say no to drugs and alcohol. Recovering impaired physicians are a critical part of the nidus and core of that leadership. Identifying, treating, and saving an impaired physician and thus producing the "ripple effect" is one of the most important contributions that MAG has made not only to Georgia but also to the whole nation.

G. Douglas Talbott, M.D.
Guest Editor and
Program Director
MAG Impaired Physicians Program

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Twelve years ago, most states had no committees to deal with impaired physicians and apparently were not even thinking of starting them. The situation has changed dramatically since then.

Physician Impairment: Past, Present, Future

E. M. STEINDLER, M.S., ***Chicago, Illinois****

TWELVE YEARS AGO, the AMA's House of Delegates adopted a landmark report of the Council on Mental Health entitled "The Sick Physician," and thereby set in motion a sustained AMA initiative in the impaired physician field.

In 1972, a major national effort certainly was indicated. In preparing its report, the Council on Mental Health had undertaken two surveys. One asked state medical societies whether they had committees to deal with physicians who were addicted or psychiatrically impaired. Only seven responded that they had active working committees of this kind. Most states had no committees and apparently were not even thinking of starting them. Three associations, in fact, became very upset over the implication that they had alcoholics, drug addicts, or mentally ill persons among their membership.

The AMA developed model legislation for amending state medical practice acts so that treatment alternatives could be made available to augment punitive measures in disciplinary proceedings.

In the other survey, the Council decided to look at disciplinary actions taken by three state boards of medical examiners. In Arizona, it found that over an 11-year period, 3.2% of that state's physicians had to be disciplined because of alcohol problems, 1.7% because of drugs, and 1.3% because of mental illness. In Oregon, over a 10-year span, 2.3% of that state's physicians had come before the board because of alcohol problems, 2.2% because of drug abuse, and 0.9% because of mental illness. In Connecticut, where statistics were kept only on drug abuse, 0.9% had come to the board's attention over a 6-year period because of addiction.

These surveys revealed that a significant problem existed, and that little was being done to deal with it. The key sentence of the ensuing Council report was, "It is a physician's ethical responsibility to take cognizance of a colleague's inability to practice medicine adequately by reason of physical or mental illness including alcoholism or drug dependence." When the House of Delegates adopted the report in 1972, that sentence became AMA policy.

What has transpired over the past 12 years is largely an explication and implementation of that policy and of two key recommendations made by the Council in its report. One major recommendation was that state medical societies establish definable programs or committees devoted to identifying and helping the impaired physician. The other was directed toward state boards of licensure and medical discipline. It proposed that the AMA develop model legislation for amending state medical practice acts so that treatment alternatives could be made available to augment punitive measures in disciplinary proceedings.

These two approaches reflected the AMA's dual concerns of (1) helping and restoring to optimal professional functioning physicians who are ill, and (2) safeguarding the health of patients who might otherwise be subject to deficient medical care or other hazards at the hands of physicians whose ability to practice becomes impaired.

A model act *was* formulated, and now some 35 states have changed their medical practice laws to incorporate the principal features of this model legislation. In addition, all 50 state medical associa-

* Mr. Steindler is Director, Human Behavior Program, American Medical Association, 535 N. Dearborn St., Chicago, Illinois 60610.

tions today have mechanisms to deal with impaired physician problems, and this development has come about because of the persistence and dedication of key individuals in the AMA and in states throughout the country.

Of major importance have been AMA's national conferences, held at regular intervals over the years. These conferences have given everyone a chance to share ideas and experiences and to examine in detail methods that have worked and those that have failed so that practical improvements could be made in ongoing programs.

State societies in Georgia and Washington, for example, have crafted sophisticated methods for confronting impaired colleagues and successfully inducing them to recognize their problems and to agree to accept help.

Among the state medical societies, noteworthy models have been developed, based on a variety of approaches to deal with the impaired physician. Societies in Georgia and Washington, for example, have crafted sophisticated methods for confronting impaired colleagues and successfully inducing them to recognize their problems and to agree to accept help. Other models have delineated effective and close-working relationships between the state medical association and the state medical disciplinary board.

In the matter of providing financial assistance to physicians who need help during their treatment or when they attempt to resume practice, the state societies in Michigan and Kansas have set up exemplary mechanisms. Finally, taking into account the full range of concern for the impaired physician from initial identification through intervention, inducement into treatment, rehabilitation, re-entry, and re-education, we can again look to the state association programs that are operational in New Jersey, Ohio and Wisconsin, for examples, in addition to Georgia.

We have learned a good deal about the actual treatment of impaired physicians, too. Doug Talbott in Georgia has shown the value of a staged inpatient-outpatient approach to the treatment of alcoholic and drug-dependent physicians, combined with supportive self-help groups and with involvement of the recovering physician in the treatment of others and in the sensitization of medical students.

Bob Morse and associates at the Mayo Clinic have compared physicians with non-physicians in their alcoholism and drug dependence treatment unit and have found that physicians have a recovery rate appreciably higher than others; eight out of ten, in fact, have had successful treatment outcomes there. LeClair Bissell in New York and Marshall Goby in Illinois also have discovered that success rates for alcoholic physicians are high, both absolutely and comparatively. Don Wesson in California and Mark Gold in New Jersey, in studies of the use of naltrexone in the maintenance treatment of opiate addicts, have confirmed that the outlook for physicians is optimistic. Because this maintenance drug requires a high degree of motivation by the patient for treatment efficacy, these studies supply additional evidence that physicians, once they are convinced they have a problem and need help, are a determined group when it comes to wanting to overcome their disease and restoring themselves as professionals and as human beings. The propensity of physicians to be high achievers, which can be a risk factor for impairment, can thus be utilized as an asset in the treatment and recovery process.

We have also learned some things about how to treat mental illness in physicians. The late Manuel Pearson exhorted his psychiatric colleagues to accept physicians as patients, just as they would accept other individuals. His concern at the time was that the psychiatric profession not turn its back on physicians who were mentally ill, and in that sense he was right; physicians are just as vulnerable and just as deserving as other patients who need help.

We need to be assertive and forthright in our determination to overcome the stigma that still too often attaches to those who have had alcoholism, drug dependence, or mental illness.

But in another sense, the "physicianhood" of the physician cannot be swept aside. This is particularly true in the treatment of the psychiatrically ill. Doug Sargent and the late Herb Raskin in Michigan pointed out early that the specialness of the physician-patient must be recognized by the therapist and that there can be a consequent expression and demonstration of what they termed "collegial regard" for the patient-as-a-physician by the therapist.

We have seen this concept extended, in a way, to the medical family in trouble — the physician, his spouse and children — in programs that have been successfully conducted through the leadership of Don Keith and others in the American Academy of Family Practice.

These have been just a few examples of the substantive advances that have been made on several fronts during the past 12 years. I know they will be the foundation for even greater advances in the next decade. And we will need to keep advancing and building to deal with some important issues still unresolved.

I see at least six issues that will require renewed attention and effort in the coming years.

1. We need to come to wider agreement on what we mean and don't mean by impairment. We have generally held to the parameters of alcoholism, drug dependence, and mental illness. I think that is wise. Much of our success, I believe, has stemmed from the fact that we have not attempted to spread ourselves thin by responding to every problem of physician disability, incompetence, poor judgment, moral turpitude and ignorance. Yet, occasions exist when the boundary lines are not clean-cut, when to be too rigid would mean ignoring some individuals and circumstances that could benefit from effective intervention.

The propensity of physicians to be high achievers, which can be a risk factor for impairment, can . . . be utilized as an asset in the treatment and recovery process.

2. We need to do much more than we have done thus far in the detection of that portion of the physician impairment problem that does involve psychiatric illness. More psychiatrists should become active in our impaired physician programs and in a way that our outreach efforts will encompass, not exclude, physicians who do not have primary problems of chemical dependence.
3. We need to refine research into the epidemiology of physician impairment — especially its incidence and prevalence — and into more precise determinations of etiology so that realistic and workable methods of prevention can be devised and pursued.
4. We need to be assertive and forthright in our determination to overcome the stigma that still, too often attaches to those who have had alcoholism, drug dependence, or mental illness. This becomes especially crucial when physicians attempt to pick up the pieces of their lives, after successfully undergoing treatment and rehabilitation, or when medical students who have had these problems and drop out of school try to resume their training.
5. We need to address in a more concerted and comprehensive fashion the whole spectrum of adequate funding for impaired physician activities, including medical society programs and government agency programs. And we need to address the financial problems of impaired physicians themselves as they enter and continue in treatment and begin to reestablish themselves in their communities.
6. We need to extend our hand to other health professionals and offer them what we have learned, and will yet learn, about this problem in physicians; in turn, we may gain valuable insights from their own perspectives.

If we make significant strides in these six areas in the coming years, we will be able to continue to take justifiable pride in what we are accomplishing. But I can also see some longer-range implications of the impaired physician movement.

First, I think this movement will soon underscore for the profession and the public alike the fact that the physician is a human being — that he is subject to the same weaknesses and disorders as others, yes, but equally, that he is capable of fighting back, of having his health restored, of prevailing.

I hope that a corollary of this recognition can be a revitalization of the physician/patient relationship, whereby the physician will become more sensitive to the human qualities and attributes of his patients and will gain a greater awareness of the nature and impact of problems associated with alcohol and drug abuse, mental illness, and behavior disorders.

We need to address in a more concerted and comprehensive fashion the whole spectrum of adequate funding for impaired physician activities, including medical society programs and government agency programs.

I believe that the physician will, as a result of what we do, become more attentive to his or her own personal health and recreational needs and will view them in the context of the health and well-being of spouses and children.

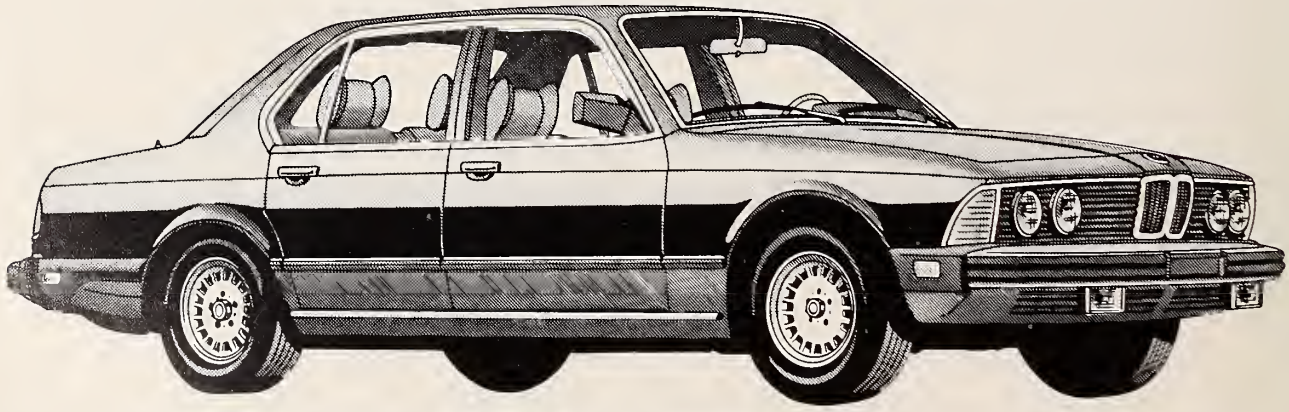
Ultimately, I am convinced that our efforts will be successful in helping physicians and patients alike realize that the promotion and safeguarding of good physical and mental health is the best and foremost means of preventing impairment of all types.

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The history of the Program is a story of people and their commitment to helping disabled doctors.

An Historical Review of Georgia's Impaired Physicians Program

CAROLYN ANNE MARTIN, PH.D., *Atlanta**

Introduction

In 1972, The American Medical Association recognized chemical dependence among physicians as a serious problem.[1] The extent of the problem continues to become more apparent annually as greater numbers of chemically dependent physicians are identified and as the list of social and medical problems related to their disease increases. As of 1984, all 50 state medical societies reported having impaired physicians programs (some have yet to be implemented) to meet the needs of this population.[2] Georgia's Impaired Physicians Program (IPP) has been described as one of the national models of treatment.[3]

Historical Sketch

The history of the Impaired Physicians Program (IPP) is a story of people and their commitment to helping disabled doctors.[4-6] IPP was started in 1974 when Thomas Vinson, M.D., and Ken Shoemaker, M.D., Health Officers for DeKalb County, Georgia, went to Baltimore, Maryland, to ask G. Douglas Talbott, M.D., to take over the alcohol and drug (A&D) treatment program for north and central DeKalb County. At that time, Talbott headed up the Public Inebriate Program in Baltimore. Talbott agreed to come to Georgia. Working with Shoemaker, Talbott started implementing his treatment model at Central DeKalb Mental Health Clinic. There, under the auspices of the DeKalb Medical Society, Talbott also implemented an advocacy program especially designed for chemically dependent physicians.

From the beginning, the objectives of IPP were threefold:[4] (1) To identify doctors who are chemically dependent on alcohol and other mood-altering substances; (2) To persuade doctors to seek treatment voluntarily; and (3) To provide effective means for dealing with those doctors who have been diagnosed as chemically dependent but who deny their disease or refuse to complete treatment.

Early Stage

The Impaired Physicians Program has gone through a number of stages of development. The period from 1974 through 1975 can be called the early stage. Originally named the Disabled Doctors Program, it was truly a grass roots organization, characterized by spontaneous response to the needs of individual cases. There was little established protocol to fall back on except a philosophy of advocacy and a basic treatment model similar to that used in Alcoholics Anonymous. The Program evolved through trial and error. When procedures did not work, they were changed. When they did work, they were left alone.

Talbott became the program director of the Disabled Doctors Program and was the first recovering physician in the informal "peer" support group. Others soon joined him. One recovering physician "came out of the closet." Then Father Damian from the Monastery of the Holy Spirit in Conyers, Georgia, referred a disabled dermatologist from Alabama, and a contact at Lockheed called to report that the man washing dishes at the Sheraton Hotel was a physician. He soon became the fourth member of the group. To accommodate the two destitute doctors who had just joined the group, a room was rented at the Candler, a run-down hotel in Decatur.

* Dr. Martin is a counseling and consulting psychologist and Editorial Director of Research for the Impaired Physicians Program. Send reprint requests to her at 3384 Peachtree Rd., Ste. 308, Atlanta, GA 30326.

Initially, DeKalb General Hospital was available for detoxification. Inpatient treatment, if needed, was obtained at Chitchat Farm in Pennsylvania or at Willingway Hospital in Statesboro, Georgia. The outpatient day program was conducted at Central DeKalb Mental Health Center. IPP planning sessions and activities centered around Central DeKalb and the Talbott's home. IPP occupied top priority for the staff, but it existed in addition to members' other professional responsibilities which afforded them their livelihood. This state of affairs continued for a number of years for all the staff and presently still applies to some who continue to devote many hours to program duties without reimbursement, since certain important projects, such as the nurses' program, have not been funded.

In the beginning, there was little established protocol to fall back on except a philosophy of advocacy and a basic treatment model similar to that used in Alcoholics Anonymous.

The first assistant in the IPP endeavor was a woman named Polly Talbott, Doug Talbott's wife. She had been his assistant in many projects before IPP and has been since. A strong, determined, and compassionate woman, Polly had, 7 years before, intervened in the course of her husband's active alcoholism and helped him get treatment. She then began to work with her husband toward implementing his dream of helping other physicians before they had to experience the same pain and loss he had. In addition to managing a large family, Polly has continued to work officially and unofficially in all Talbott's projects. She continues to present a fresh perspective on IPP issues.

Another woman was awaiting Talbott's arrival in Georgia in 1974, and she became an able assistant. She is still with him and today primarily makes contacts and performs follow-up interviews for IPP. Margaret Clements has been a major driving force behind this program since its beginning. Until recently (when the number of patients in treatment drastically increased), Clements personally knew each person coming into the Program. She found the resources needed by patients and their families, as well as staff members and visiting dignitaries. Clements also enlisted the help of a reservoir of community resources: prominent figures in medical schools, medical societies, and medical auxiliaries, to name a few. Maybe Clement's greatest contribution has been the continuity she presents for patients through all phases of treatment and beyond and the compassionate care she has provided for families in the years of follow-up interviews.

Many other people have also helped make this Program a reality. Some were professionals who, having received treatment in the Program, stayed on afterward to work full-time. Others volunteered part-time after treatment, and still others who were not chemically dependent themselves but were dedicated to providing quality treatment for addicted physicians sought to work in the Program. This latter group offset the perspective of recovering staff members and provided a needed balance.

Launching IPP Statewide

Physicians at both the county and state level have made substantial contributions to the success of IPP. Key figures in the DeKalb Medical Society, while helping to start IPP, were aware that it needed to be state-sponsored to be effective. In 1975, Dr. Ernest Atkins, Secretary of the Medical Association of Georgia, and Mr. Hank Holderfield, Executive Director of the DeKalb Medical Society, presented the needs of the project to the MAG.

Initially, funds were scarce, because the real need for this Program in Georgia was not apparent. The first year of operation (1974), a few physicians privately funded the project, with some gas money being furnished by Father Damian. The second year, $800 was received from MAG, the third year $900, and the fourth year the Director and advisors decided to go for broke. Atkins and Holderfield asked MAG for a $30,000 grant. The MAG House of Delegates was meeting at Jekyll Island; 280 physicians from all over Georgia were voting on the various projects presented to them. Dr. L. Newton Turk, III, played a major role in getting support from MAG, and Dr. A. Cullen Richardson, Jr., was also a staunch supporter. By this time, 22 physicians had gone through the Program, and some of them joined Talbott in convincing the Board of the importance of the Program.

In 1976, the basic model of IPP was expanded to include other health care professionals.

With the first MAG grant in 1975, the Impaired Physicians Program was officially christened; however, as previously mentioned, it had already been in operation for a year at Central DeKalb, an extension of DeKalb General Hospital. There, Pat Harwell, in addition to working with Adel Burnsed, Margaret Clements, and Doug Talbott in detox, led an educational group for families, involving them in the recovery process as much as possible. Judy Gray trained physician-patients in the use of non-chemical coping skills, and Cecilia Godfrey and Wade Hopkins were among the staff members who led various

types of groups in addition to their other duties. Physician-patients early in treatment were introduced to Alcoholics Anonymous. An extra feature of IPP consisted of recovering doctors and their wives getting together informally once a week at the Talbott's house. The formal peer program known as the Caduceus Club was not formed until 1976.

Middle Stage

In 1976, the IPP, moved to the Georgian Clinic, which Talbott renamed the DeKalb Addiction Clinic (DAC). It accommodated both north and central DeKalb County residents. With this move, the successful elements of the early stage of IPP were retained, and new elements were added. Halfway houses were opened during the DAC period, operated by Metropolitan Atlanta Recovery Residences (MARR) and directed by Donnie Brown, who earlier, as a Vocational Rehabilitation counselor, had worked with the Impaired Physicians Program.

In 1976, the basic model of IPP was expanded to include other health care professionals. Pat Harwell directed the Impaired Nurses Program until 1984. Mary Alice Giblin currently has this responsibility in addition to being aftercare coordinator. Together, these two women (with the help of others) have attempted to sensitize the staff to the special needs of women in general and female nurses in particular. Female physicians and male nurses, two important minority groups in treatment, are believed to have special issues in treatment and are currently being assessed in this evaluation. The two other health professionals programs which began in this period are the Dentists Program, directed by Eugene Willis, and the Pharmacists Program, directed by Gary Bunting.

Current Stage

In 1977, the IPP moved to Metropolitan Hospital on Juniper Street in Atlanta. Within the year, the Metro group opened Ridgeview Institute in nearby Smyrna, Georgia. IPP headquarters moved as well, since Talbott accepted the position of Program Director of the adult chemical dependence unit there. The four phases of treatment were begun at Metro. Specialized inpatient treatment was provided locally without regard to location of residence. Halfway houses begun at DAC were expanded. Volunteers from the Junior League of Atlanta, Inc., acted as counselors.

In 1977, when IPP headquarters moved to Ridgeview Institute, Program activities expanded and intensified and some major shifts in protocol occurred. The major change was the insistence by staff that patients sign an initial treatment contract committing themselves to all four phases of treatment. Another innovation, The Caduceus Foundation, was begun around 1978 by Dr. Jim Mashburn to seek charitable contributions and to supervise allocations of funds for IPP. Mr. A. B. Padgett, the current president of the Caduceus Foundation Board, has been associated with The Foundation since its beginning and has generously given of his time and extensive knowledge of community resources and the business community.

Some of the key figures of IPP's current stage of development continue with the program today. Karen Trull Keel came to Ridgeview in 1977 to run Talbott's office. As Office Manager, she sees to it that the various programs administered by that office function smoothly. She supervises preparations for meetings, speaking engagements, and various activities, in addition to supervising the ongoing treatment programs.

This is a tough program, run by people who have been there themselves or who have had first-hand experience with the life-and-death nature of chemical dependence.

Another person Talbott has relied on heavily is Dr. Phil Wilson, an addictionologist and internist who came on the staff in 1979. Wilson is acting director when Talbott is out of town and provides continuity and stability to the Program on a daily basis. He is Medical Director of the Impaired Health Professionals Program and Chairman of its Executive Committee, in addition to his other responsibilities.

Talbott has been the only Program Director for IPP, but there have been three official Medical Directors. Dr. Marshall Follo was the first, followed by Dr. Earl Benson; Dr. William Farley took over in March 1982. Each director has had other professional responsibilities but has spent a great deal of time overseeing the treatment regimen of IPP.

With the tightening of the treatment regimen came the formation of CORR (Caduceus Outpatient Recovery Residences) in 1982 and SAFE (Substance Abuse Free Existence), the outpatient treatment program, in 1983. CORR was originated by the Caduceus Foundation, then turned over to SAFE to operate. SAFE Centers, Inc., a national outpatient treatment program, provides Phase II of treatment for Georgia's IPP.

Georgia's current Impaired Physicians Program has become more complex as it has grown. Ridgeview, CORR, and SAFE have become associated to provide a continuity of treatment and a large peer support group for health professionals. Patients are not automatically placed in these facilities, however. Other treatment programs are sometimes recommended by the Treatment Management Team for

patients who have a special need or for those who do not do well in the local facilities.

Because the headquarters of IPP is located at Ridgeview and because the staff knows personnel from both Ridgeview and SAFE, IPP can hire professionals from these programs to work after hours as needed on a part-time basis or they can hire permanent staff from this professional pool (and vice versa). IPP utilizes all the facets of this specialized treatment association, yet maintains its autonomy and its primary affiliation with MAG.

The Continuing Role of MAG

IPP continues to have a place of priority in MAG in a number of ways. It is the largest line item in MAG's budget. MAG assists in the identification of and intervention with impaired physicians as well as provides input for the implementation and modification of IPP. It provides advocacy for physicians completing the Program and applies pressure on those who deny their disease or who leave treatment. Pressure consists of notification of the state licensing board and DEA authorities after repeated attempts to get the doctor back into treatment have failed and after ascertaining that no personal rights have been abridged.

Without the support and cooperation of the MAG, the Impaired Physicians Program would have remained a dream and lost the opportunity to save hundreds of physicians' lives.

Two committees at MAG have had primary responsibility for IPP and have provided assistance to the Program. The first is the Physicians Consultants Committee, chaired by Talbott. This committee helps to implement the policy decisions made by the second committee, the Impaired Physicians Commitee. Over the years, the able chairmen of this latter committee, Drs. Cullen Richardson, Jr., Jim Mashburn, and Ed Waits, have provided strong leadership for the Program and have set the direction for its future course. Another MAG committee, the Professional Conduct and Medical Ethics Committee, functions as an advocate for the impaired physician and as the protector of the medical community as a whole. It works with the local medical societies and with the Georgia Composite State Board of Medical Examiners. Dr. James Anthony, the Medical Coordinator for the Board, has worked closely with IPP since its inception to help get impaired physicians into treatment.

Summary

From its beginning, Georgia's IPP has been associated with G. Douglas Talbott, both personally and professionally. It was his dream and has become a reality; it has moved with him wherever he has gone. IPP has been criticized by some as being too closely tied to Talbott's personality; however, the people who have succeeded in the Program and the staff who remain with IPP do so at least partly because of their relationship with Talbott. They rely on him far more than as the director, and he responds. Others do, too. In that sense, IPP is still a grass roots organization. The Program responds spontaneously and humanely to individual needs. Even though it has grown considerably, with a new computerized Data and Research Division just beginning to evaluate treatment outcome, responding to human concerns is IPP's top priority. The Program is presented as an advocacy program, yet no one refuses to use coercion if needed to insure the safety and well being of the public or to persuade a resisting physician to enter treatment. Nor do staff members hesitate to transfer a patient who breaks the rules. This is a tough program, run by people who have been there themselves or who have had first-hand experience with the life-and-death nature of chemical dependence.

IPP is a dynamic organization that brings together many opposites and achieves a workable blend. The diverse professional disciplines and personal philosophies of its staff and treatment modalities are used for the benefit of the patients. How well IPP continues to function in the future depends on how well it continues to meet the needs of chemically dependent health professionals.

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The tools for preventing relapse or for turning it into a higher quality recovery program are provided in the four elements of the Program discussed in this paper.

Elements of the Impaired Physicians Program

G. DOUGLAS TALBOTT, M.D., *Smyrna**

MAG's Impaired Physicians Program (IPP) consists of four elements which have evolved from experience over the past 10 years: identification, intervention, treatment, and re-entry. All four elements are essential to the successful rehabilitation of Georgia's impaired physician.

Identification

The identification of impaired physicians is profoundly affected by their characteristic massive denial. Their almost phobic inability to reach out for help, combined with the conspiracy of silence evidenced by family, peers, friends, and even patients, makes identification very difficult. After analysis of the progression of the disease in the first 100 patients in IPP, it became apparent that the signs and symptoms used as identification criteria occurred first in the home and family setting, then sequentially in the community and the church and in financial, legal, and health problems. Symptoms were apparent last at the office or the hospital. When impaired physicians arrive in an altered state of consciousness at their job, it is usually very late in the disease and the rest of their lives are already in turmoil.

Symptom inventories in the form of checklists have been prepared[1] and are utilized for early identification of the impaired physician. Inherent in identification is verification which is accomplished by confirming the diagnosis with the IPP network of recovering physicians, spouses, administrators of hospitals, medical society staff, nurses, and friends in the self-help groups. Such verification is possible because of extensive educational efforts throughout the states to establish this Program as a non-punitive, advocacy, disease model.

Intervention

The second element of the program, intervention, is dictated by the denial characteristic of impaired physicians and their inability to reach out for help. In the vast majority of physicians, motivation for treatment is dependent upon intervention. Following hundreds of interventions with impaired physicians, guidelines have been established,[2] the use of which has recently been demonstrated in a videotape. Basic to this approach is the requirement that this intervention be implemented by at least two physician intervenors; ideally, one of these is recovering from the disease of chemical dependence. The intervenors, who are carefully trained in the facts of this psychosocial biogenetic disease, must also be carefully instructed and practiced in dealing with denial, anger, and hostility.

Intervention without the implied authority and consequences of the MAG and/or the licensing board is usually doomed to failure.

Representing the Medical Association of Georgia, these intervenors, who are selected because of absence of personal or professional relations with the impaired physician, must have also carefully done their homework. This homework consists mainly of careful documentation of evidence of the disease and is accomplished by interviewing and

* Dr. Talbott is an addictionologist and Program Director of MAG's Impaired Physicians Program. Send reprint requests to him at 3985 South Cobb Dr., Ste. 210, Smyrna, GA 30080.

mobilizing for the intervention the support systems of that particular impaired physician. In addition, intervenors prepare specific goals and objectives of the intervention with particular attention to the assessment and treatment plans to be presented.

When such homework is accomplished, then the support systems are brought together for instruction on the disease, for definition of their roles at intervention, and for role playing and rehearsal of the actual events. Attention to a realistic assessment of the situation and to likely responses by the physician to the intervention helps participants make a tough-minded commitment to follow through with whatever agreements have been made for negative sanctions if the person refuses help. It also helps them unequivocally accept the physician's decision to go into treatment. Careful attention is given to the selection of participants and of the time and place for the structured intervention. Adequate time is allowed in the intervention for meeting the physician's objections and for dealing with extenuating circumstances so that the goal of getting the physician into immediate assessment or treatment is accomplished. In the Georgia program, repeated interventions are utilized if the primary confrontation fails. Intervention without the implied authority and consequences of the MAG and/or the licensing board is usually doomed to failure.

Treatment

The treatment element of the Georgia Impaired Physicians Program is divided into an initial 72-hour assessment followed by four phases of treatment. The initial assessment has been found to be a very effective goal of intervention. This allows the intervention team, rather than play the role of judge and jury for the impaired physician, to emphasize that they want the impaired physician to see the "experts" who will define the problem and recommend the specific treatment course.

Five-member teams of medical specialists, psychologists and neuropsychologists, psychiatrists, family therapists, and addictionologists consult to establish the diagnosis. They differentiate chemical dependence from primary psychiatric disease and assess other medical problems; then they present specific treatment plans to the impaired physician and the family. Various treatment options are utilized for patients in the Georgia Program. These include referral to their community Alcoholics Anonymous/Narcotics Anonymous program and the prescribed plan for attending "90 meetings in 90 days," referral to outpatient alcohol and/or drug treatment only, referral to a psychiatric rather than a chemical dependence program, referral to counseling, and return to their practice or, as is true of the majority of assessment cases in the Georgia Program, referral to full treatment in the MAG Impaired Physicians Program.

With the signing of a treatment contract, all impaired physicians are regarded as entering into a 2-year treatment program, including aftercare, monitoring, and surveillance upon returning home. IPP's treatment regimen consists of four phases.

Symptom inventories in the form of checklists have been prepared and are used for early identification of the impaired physician.

Phase 1 is a 4-6-week intensive inpatient treatment program which may or may not be completed at Ridgeview Institute, where the majority of the treatment team is located. The Ridgeview model (as do the other approved programs) stresses the disease precept of chemical dependence and emphasizes family therapy, AA/NA, a strong personal spiritual program, group therapy, non-chemical coping skills training, and detailed education on the psychosocial, biogenetic characteristics of the disease of alcoholism and drug addiction. In Phase 1, true peer group therapy is initiated to deal with special problems and influences that uniquely affect those in the medical profession (dealt with in detail in the other articles of this issue of the *Journal*). In the peer groups, physicians meet with physicians, dentists with dentists, pharmacists with pharmacists, and nurses with nurses. They consist of people in various phases of treatment. These special peer groups continue throughout the 4 months and beyond for those people in the area.

Following Phase 1, the impaired physician enters into Phase 2, which consists of outpatient therapy and supervised living in a recovery residence. The outpatient program at a SAFE (Substance Abuse Free Existence) Center is an extension of the medical model established at Ridgeview. Determined by the severity of an individual's disease, this phase lasts 1-2 months and provides further practice in non-chemical coping, development of a stronger spiritual program, and deeper involvement in AA/NA with intense family therapy. Caduceus Outpatient Recovery Residences (CORR) utilize rented apartments and houses in the metropolitan Atlanta area, and these recovery residences serve as a site for surrogate family living. For 90 days, impaired physicians live there, going to 90 meetings of AA/NA, participating in supervised group therapy four times a week, and learning in that ambience to care again, to trust, to socialize, to communicate, and to assume personal accountability for their own behavior.

Phase 3 is completed when impaired physicians.

while continuing to live in the recovery residence, are judged able to move from strict patient status to that of counselor-trainees under strict supervision. As they become frustrated and try forcefully to get the addict or alcoholic they are supervising to break through denial, to deal with depression, anger, or hostility, or to mend family wounds, they can see themselves. This "mirror image" therapy is a very constructive experience lasting for a minimum of 2 months. Concomitant with this work, impaired physicians also teach, dialogue, and interact with medical students at Emory University School of Medicine. Dealing with these students in a variety of seminars, lectures, and workshops restores professional dignity while cleansing the impaired physician of the embarrassment, shame, and guilt that society assigns to this disease. In turn, the medical students acquire a new dimension regarding this disease — that indeed it could happen to them.[3]

Re-Entry

The last phase of the treatment process, re-entry, is considered a separate element. Having already signed a treatment contract and having completed the 4 months of treatment, impaired physicians enter into a 20-month aftercare contract which provides for a primary monitoring physician and for random drug screens. It also states the agreed on schedule of AA/NA meetings and choice of "sponsor" in the AA/NA program. In addition, the elements of a personal spiritual program and further recommendations for a family therapy program are carefully detailed.

. . . the value of the aftercare phase lies in its extension to provide support during transition to community-based support.

Another document, called "Relapse Guidelines," is also signed (See pp. 767-768). Rather than a firm contract, the Guidelines give certain suggestions to guard against relapse and to interrupt it if it does occur. Georgia's Program recognizes that chemical dependence is a relapsing disease and, while the Program does not give permission for relapse to occur, it recognizes that possibility. Procedures such as obtaining drug screens, calling the primary monitoring physician, calling the treatment center, and mobilizing the impaired physician's support systems are outlined for physicians to utilize before, and certainly after, using a mood-altering chemical. The guidelines also suggest procedures for families or supervisors to use when they are concerned about the physician's relapse.

Just as the effectiveness of the initial phase of treatment is dependent on its intensity to break through denial, the value of the aftercare phase lies in its extension to provide support during transition to community-based support. Twenty months allows for structured contacts to be maintained through the first 2 years after which, according to our data, the risk of relapse drops significantly.[4]

In addition to the aftercare contract and the relapse guidelines, the re-entry phase is ideally characterized by continuous contact with the Caduceus Club network, the primary care physician, and the treatment center. In actuality, many physicians are miles from other recovering physicians. Other than frequent calls to contacts at IPP, they rely on AA/NA networks and sponsors for the support they need to stay sober. International Doctors in Alcoholics Anonymous (IDAA) offers further personal and professional support. Composed of physicians and Ph.D. psychologists, IDAA has an annual meeting and other informal meetings in conjunction with various conferences.

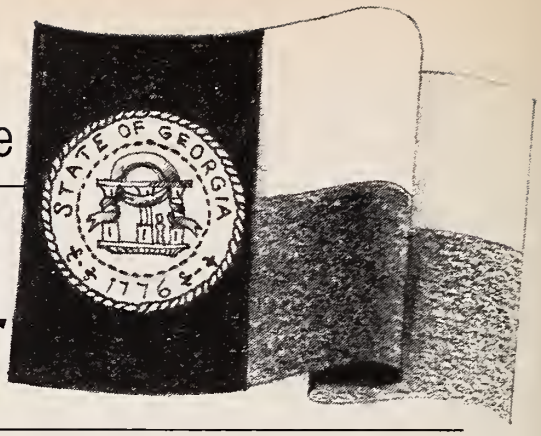
The long-term goal of Georgia's Impaired Physicians Program is that each physician who completes the treatment regimen will have acquired an emotional and spiritual commitment to "go to any lengths" to stay sober and live a productive and rewarding life, 24 hours at a time. The tools for preventing relapse or for turning it into a higher quality recovery program are provided in the four elements of the Program discussed in this paper.

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THE MODEST MAN OF MAJOR IMPORT



Dr. Crawford W. Long

One of the most important discoveries in medicine was the use of ether in surgical procedures, and its revelation was delayed because of the inordinate modesty of Dr. Crawford W. Long, its first successful user.

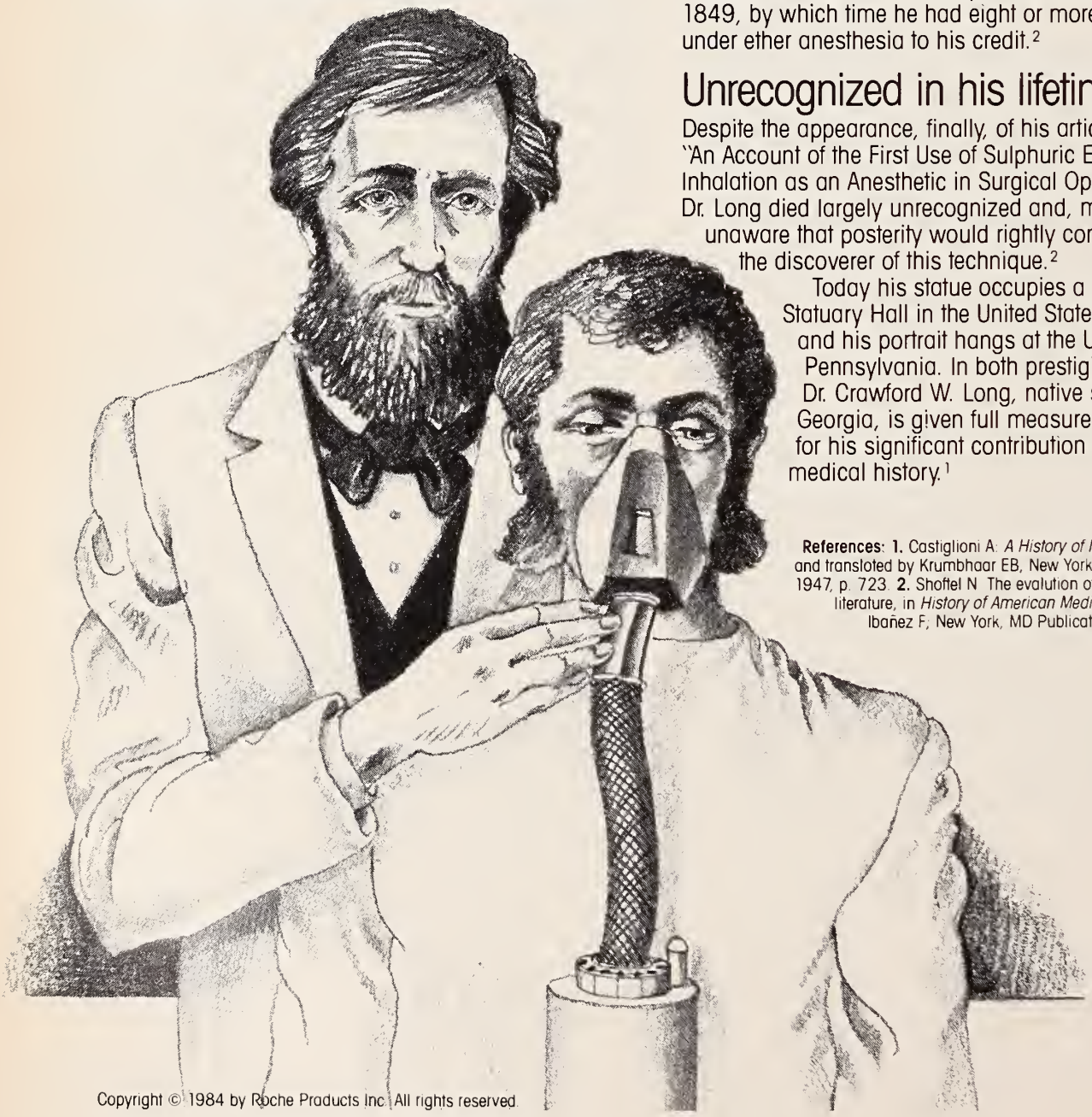
A simple country practitioner in Jefferson, Georgia, Dr. Long had little surgical experience when, on March 30, 1842, he experimented with the use of sulfuric ether as an anesthetic in the surgical removal of a small septic tumor from the neck of a patient. The patient, James Venable, reported feeling no pain during the incision and removal proceedings, and soon recovered.[1,2]

Pleased by the results of surgery under anesthesia, Dr. Long continued to use ether in surgery and obstetrics. Recognition for his accomplishment was limited, however, because he did not publish his discovery until 1849, by which time he had eight or more operations under ether anesthesia to his credit.[2]

Unrecognized in his lifetime

Despite the appearance, finally, of his article titled "An Account of the First Use of Sulphuric Ether by Inhalation as an Anesthetic in Surgical Operations," Dr. Long died largely unrecognized and, most assuredly, unaware that posterity would rightly consider him the discoverer of this technique.[2]

Today his statue occupies a place in Statuary Hall in the United States Capitol, and his portrait hangs at the University of Pennsylvania. In both prestigious locations, Dr. Crawford W. Long, native son of Georgia, is given full measure of respect for his significant contribution to medical history.[1]



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***Usage in Pregnancy:* Use of minor tranquilizers during the first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.**

Since physical and psychalagical dependence ta chlardiazepaxide have been reparted rarely, use cautian in administering Limbitral ta addictian-prane individuals ar thase wha might increase dasage; withdrawal symptams fallawing discantinuatian af either campanent alane have been reparted (nausea, headache and malaise for amitriptyline; symptams [including canvulsians] similar ta thase af barbiturate withdrawal far chlardiazepaxide).

Precautions: Use with cautian in patients with a histary af seizures, in hyperthyraid patients or thase an thyraid medication, and in patients with impaired renal ar hepatic function. Because af the passibility af suicide in depressed patients, da nat permit easy access ta large quantities in these patients. Periadic liver function tests and blaad caunts are recommended during pralonged treatment. Amitriptyline campanent may black actian af guanethidine ar similar antihypertensives. Cancamitant use with ather psychatrapic drugs has nat been evaluated; sedative effects may be additive. Discantinue several days before surgery. Limit cancamitant administratian af ECT ta essential treatment. See Warnings far precautians abaut pregnancy. Limbitral shauld nat be taken during the nursing period. Nat recammended in children under 12. In the elderly and debilitated, limit ta smallest effective dasage ta preclude ataxia, oversedatian, canfusian ar antichalinergic effects.

Adverse Reactions: Mast frequently reparted are thase associated with either campanent alane: drawsiness, dry mauth, canstipatian, blurred visian, dizziness and blaating. Less frequently accurring reactians include vivid dreams, impatence, tremar, canfusian and nasal congestian. Many depressive symptams including anarexia, fatigue, weakness, restlessness and lethargy have been reparted as side effects af bath Limbitral and amitriptyline. Granulacytapenia, jaundice and hepatic dysfunctian have been abserved rarely.

The fallawing list includes adverse reactians nat reparted with Limbitral but requiring consideratian because they have been reparted with ane ar both campanents ar clasely related drugs:

Cardiovasculor: Hypatensian, hypertensian, tachycardia, palpitatians, myacardial infarctian, arrhythmias, heart black, strake.

Psychiotric: Eupharia, apprehensian, paar cancentratian, delusians, hallucinatians, hypamania and increased ar decreased libida.

Neurologic: Incaardinatian, ataxia, numbness, tingling and paresthesias af the extremities, extrapyramidal symptoms, syncape, changes in EEG patterns.

Anticholinergic: Disturbance af accammadatian, paralytic ileus, urinary retentian, dilatatian af urinary tract.

Allergic: Skin rash, urticaria, phatasensitizatian, edema af face and tangue, pruritus.

Hemotologic: Bane marraw depressian including agranulacytasis, easinaphilia, purpura, thrambacytapenia.

Gostrointestinol: Nausea, epigastric distress, vamiting, anarexia, stamatitis, peculiar taste, diarrhea, black tangue.

Endocrine: Testicular swelling and gynecamastia in the male, breast enlargement, galactarrhea and minar menstrual irregularities in the female, elevatian and lawering af blaad sugar levels, and syndrome af inappropriate ADH (antidiuretic harmane) secretian.

Other: Headache, weight gain ar lass, increased perspiratian, urinary frequency, mydriasis, jaundice, alapecia, paratid swelling.

Overdosage: Immediately hospitalize patient suspected af having taken an averdase. Treatment is symptamatic and suppartive. I.V. administratian af 1 ta 3 mg physastigmine salicylate has been reparted ta reverse the symptams af amitriptyline paisaning. See complete product infarmatian far manifestatian and treatment.

Dosage: Individualize according ta symptam severity and patient respanse. Reduce ta smallest effective dasage when satisfactary respanse is abtained. Larger partian af daily dase may be taken at bedtime. Single *h.s.* dase may suffice far some patients. Lawer dasages are recammended far the elderly.

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*Cardizem is indicated in the treatment of angina pectoris due to coronary artery spasm and in the management of chronic stable angina (classic effort-associated angina) in patients who cannot tolerate therapy with beta-blockers and/or nitrates or who remain symptomatic despite adequate doses of these agents.

References:
1. Strauss WE, McIntyre KM, Parisi AF, et al: Safety and efficacy of diltiazem hydrochloride for the treatment of stable angina pectoris: Report of a cooperative clinical trial. Am J Cardiol 49:560-566, 1982.
2. Pool PE, Seagren SC, Bonanno JA, et al: The treatment of exercise-inducible chronic stable angina with diltiazem: Effect on treadmill exercise. Chest 78 (July suppl):234-238, 1980.

Reduces angina attack frequency*
42% to 46% decrease reported in multicenter study.[1]

Increases exercise tolerance*
In Bruce exercise test,[2] control patients averaged 8.0 minutes to onset of pain; Cardizem patients averaged 9.8 minutes ($P<.005$).

CARDIZEM®
(diltiazem HCl)

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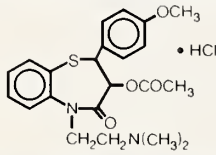
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PROFESSIONAL USE INFORMATION

cardizem®
(diltiazem HCl)
30 mg and 60 mg tablets

DESCRIPTION

CARDIZEM® (diltiazem hydrochloride) is a calcium ion influx inhibitor (slow channel blocker or calcium antagonist). Chemically, diltiazem hydrochloride is 1,5-Benzothiazepin-4(5H)one,3-(acetyloxy) -5-[2-(dimethylamino)ethyl]-2,3-dihydro-2-(4-methoxyphenyl)-, monohydrochloride,(+)-cis-. The chemical structure is:



Diltiazem hydrochloride is a white to off-white crystalline powder with a bitter taste. It is soluble in water, methanol, and chloroform. It has a molecular weight of 450.98. Each tablet of CARDIZEM contains either 30 mg or 60 mg diltiazem hydrochloride for oral administration.

CLINICAL PHARMACOLOGY

The therapeutic benefits achieved with CAROIZEM are believed to be related to its ability to inhibit the influx of calcium ions during membrane depolarization of cardiac and vascular smooth muscle.

Mechanisms of Action. Although precise mechanisms of its antianginal actions are still being delineated, CARDIZEM is believed to act in the following ways:

1. Angina Oue to Coronary Artery Spasm: CARDIZEM has been shown to be a potent dilator of coronary arteries both epicardial and subendocardial. Spontaneous and ergonovine-induced coronary artery spasm are inhibited by CARDIZEM.
2. Exertional Angina: CARDIZEM has been shown to produce increases in exercise tolerance, probably due to its ability to reduce myocardial oxygen demand. This is accomplished via reductions in heart rate and systemic blood pressure at submaximal and maximal exercise work loads.

In animal models, diltiazem interferes with the slow inward (depolarizing) current in excitable tissue. It causes excitation-contraction uncoupling in various myocardial tissues without changes in the configuration of the action potential. Diltiazem produces relaxation of coronary vascular smooth muscle and dilation of both large and small coronary arteries at drug levels which cause little or no negative inotropic effect. The resultant increases in coronary blood flow (epicardial and subendocardial) occur in ischemic and nonischemic models and are accompanied by dose-dependent decreases in systemic blood pressure and decreases in peripheral resistance.

Hemodynamic and Electrophysiologic Effects. Like other calcium antagonists, diltiazem decreases sinoatrial and atrioventricular conduction in isolated tissues and has a negative inotropic effect in isolated preparations. In the intact animal, prolongation of the AH interval can be seen at higher doses.

In man, diltiazem prevents spontaneous and ergonovine-provoked coronary artery spasm. It causes a decrease in peripheral vascular resistance and a modest fall in blood pressure and, in exercise tolerance studies in patients with ischemic heart disease, reduces the heart rate-blood pressure product for any given work load. Studies to date, primarily in patients with good ventricular function, have not revealed evidence of a negative inotropic effect; cardiac output, ejection fraction, and left ventricular end diastolic pressure have not been affected. There are as yet few data on the interaction of diltiazem and beta-blockers. Resting heart rate is usually unchanged or slightly reduced by diltiazem.

Intravenous diltiazem in doses of 20 mg prolongs AH conduction time and AV node functional and effective refractory periods approximately 20%. In a study involving single oral doses of 300 mg of CARDIZEM in six normal volunteers, the average maximum PR prolongation was 14% with no instances of greater than first-degree AV block. Diltiazem-associated prolongation of the AH interval is not more pronounced in patients with first-degree heart block. In patients with sick sinus syndrome, diltiazem significantly prolongs sinus cycle length (up to 50% in some cases).

Chronic oral administration of CARDIZEM in doses of up to 240 mg/day has resulted in small increases in PR interval, but has not usually produced abnormal prolongation. There were, however, three instances of second-degree AV block and one instance of third-degree AV block in a group of 959 chronically treated patients.

Pharmacokinetics and Metabolism. Diltiazem is absorbed from the tablet formulation to about 80% of a reference capsule and is subject to an extensive first-pass effect, giving an absolute bioavailability (compared to intravenous dosing) of about 40%. CARDIZEM undergoes extensive hepatic metabolism in which 2% to 4% of the unchanged drug appears in the urine. In vitro binding studies show CARDIZEM is 70% to 80% bound to plasma proteins. Competitive ligand binding studies have also shown CARDIZEM binding is not altered by therapeutic concentrations of digoxin, hydrochlorothiazide, phenylbutazone, propranolol, salicylic acid, or warfarin. Single oral doses of 30 to 120 mg of CARDIZEM result in detectable plasma levels within 30 to 60 minutes and peak plasma levels two to three hours after drug administration. The plasma elimination half-life following single or multiple drug administration is approximately 3.5 hours. Desacetyl diltiazem is also present in the plasma at levels of 10% to 20% of the parent drug and is 25% to 50% as potent a coronary vasodilator as diltiazem. Therapeutic blood levels of CARDIZEM appear to be in the range of 50 to 200 ng/ml. There is a departure from dose-linearity when single doses above 60 mg are given; a 120-mg dose gave blood levels three times that of the 60-mg dose. There is no information about the effect of renal or hepatic impairment on excretion or metabolism of diltiazem.

INDICATIONS AND USAGE

1. **Angina Pectoris Due to Coronary Artery Spasm.** CARDIZEM is indicated in the treatment of angina pectoris due to coronary artery spasm. CAROIZEM has been shown effective in the treatment of spontaneous coronary artery spasm presenting as Prinzmetal's variant angina (resting angina with ST-segment elevation occurring during attacks).
2. **Chronic Stable Angina (Classic Effort-Associated Angina).** CARDIZEM is indicated in the management of chronic stable angina. CARDIZEM has been effective in controlled trials in reducing angina frequency and increasing exercise tolerance.

There are no controlled studies of the effectiveness of the concomitant use of diltiazem and beta-blockers or of the safety of this combination in patients with impaired ventricular function or conduction abnormalities.

CONTRAINDICATIONS

CARDIZEM is contraindicated in (1) patients with sick sinus syndrome except in the presence of a functioning ventricular pacemaker, (2) patients with second- or third-degree AV block except in the presence of a functioning ventricular pacemaker, and (3) patients with hypotension (less than 90 mm Hg systolic).

WARNINGS

1. **Cardiac Conduction.** CARDIZEM prolongs AV node refractory periods without significantly prolonging sinus node recovery time, except in patients with sick sinus syndrome. This effect may rarely result in abnormally slow heart rates (particularly in patients with sick sinus syndrome) or second- or third-degree AV block (six of 1243 patients for 0.48%). Concomitant use of diltiazem with beta-blockers or digitalis may result in additive effects on cardiac conduction. A patient with Prinzmetal's angina developed periods of asystole (2 to 5 seconds) after a single dose of 60 mg of diltiazem.
2. **Congestive Heart Failure.** Although diltiazem has a negative inotropic effect in isolated animal tissue preparations, hemodynamic studies in humans with normal ventricular function have not shown a reduction in cardiac index nor consistent negative effects on contractility (dp/dt). Experience with the use of CARDIZEM alone or in combination with beta-blockers in patients with impaired ventricular function is very limited. Caution should be exercised when using the drug in such patients.
3. **Hypotension.** Oecreases in blood pressure associated with CARDIZEM therapy may occasionally result in symptomatic hypotension.
4. **Acute Hepatic Injury.** In rare instances, patients receiving CARDIZEM have exhibited reversible acute hepatic injury as evidenced by moderate to extreme elevations of liver enzymes. (See PRECAUTIONS and AOVERSE REACTIONS.)

PRECAUTIONS

General. CARDIZEM (diltiazem hydrochloride) is extensively metabolized by the liver and excreted by the kidneys and in bile. As with any new drug given over prolonged periods, laboratory parameters should be monitored at regular intervals. The drug should be used with caution in patients with impaired renal or hepatic function. In subacute and chronic dog and rat studies designed to produce toxicity, high doses of diltiazem were associated with hepatic damage. In special subacute hepatic studies, oral doses of 125 mg/kg and higher in rats were associated with histological changes in the liver which were reversible when the drug was discontinued. In dogs, doses of 20 mg/kg were also associated with hepatic changes; however, these changes were reversible with continued dosing.

Drug Interaction. Pharmacologic studies indicate that there may be additive effects in prolonging AV conduction when using beta-blockers or digitalis concomitantly with CARDIZEM. (See WARNINGS).

Controlled and uncontrolled domestic studies suggest that concomitant use of CAROIZEM and beta-blockers or digitalis is usually well tolerated. Available data are not sufficient, however, to predict the effects of concomitant treatment, particularly in patients with left ventricular dysfunction or cardiac conduction abnormalities. In healthy volunteers, diltiazem has been shown to increase serum digoxin levels up to 20%.

Carcinogenesis, Mutagenesis, Impairment of Fertility. A 24-month study in rats and a 21-month study in mice showed no evidence of carcinogenicity. There was also no mutagenic response in in vitro bacterial tests. No intrinsic effect on fertility was observed in rats.

Pregnancy. Category C. Reproduction studies have been conducted in mice, rats, and rabbits. Administration of doses ranging from five to ten times greater (on a mg/kg basis) than the daily recommended therapeutic dose has resulted in embryo and fetal lethality. These doses, in some studies, have been reported to cause skeletal abnormalities. In the perinatal/postnatal studies, there was some reduction in early individual pup weights and survival rates. There was an increased incidence of stillbirths at doses of 20 times the human dose or greater.

There are no well-controlled studies in pregnant women; therefore, use CARDIZEM in pregnant women only if the potential benefit justifies the potential risk to the fetus.

Nursing Mothers. It is not known whether this drug is excreted in human milk. Because many drugs are excreted in human milk, exercise caution when CARDIZEM is administered to a nursing woman if the drug's benefits are thought to outweigh its potential risks in this situation.

Pediatric Use. Safety and effectiveness in children have not been established.

ADVERSE REACTIONS

Serious adverse reactions have been rare in studies carried out to date, but it should be recognized that patients with impaired ventricular function and cardiac conduction abnormalities have usually been excluded.

In domestic placebo-controlled trials, the incidence of adverse reactions reported during CARDIZEM therapy was not greater than that reported during placebo therapy.

The following represent occurrences observed in clinical studies which can be at least reasonably associated with the pharmacology of calcium influx inhibition. In many cases, the relationship to CARDIZEM has not been established. The most common occurrences, as well as their frequency of presentation, are: edema (2.4%), headache (2.1%), nausea (1.9%), dizziness (1.5%), rash (1.3%), asthenia (1.2%), AV block (1.1%). In addition, the following events were reported infrequently (less than 1%) with the order of presentation corresponding to the relative frequency of occurrence.

Cardiovascular:	Flushing, arrhythmia, hypotension, bradycardia, palpitations, congestive heart failure, syncope.
Nervous System:	Paresthesia, nervousness, somnolence, tremor, insomnia, hallucinations, and amnesia.
Gastrointestinal:	Constipation, dyspepsia, diarrhea, vomiting, mild elevations of alkaline phosphatase, SGOT, SGPT, and LDH.
Dermatologic:	Pruritus, petechiae, urticaria, photosensitivity.
Other:	Polyuria, nocturia.

The following additional experiences have been noted:

A patient with Prinzmetal's angina experiencing episodes of vasospastic angina developed periods of transient asymptomatic asystole approximately five hours after receiving a single 60-mg dose of CARDIZEM.

The following postmarketing events have been reported infrequently in patients receiving CAROIZEM: erythema multiforme; leukopenia; and extreme elevations of alkaline phosphatase, SGOT, SGPT, LDH, and CPK. However, a definitive cause and effect between these events and CARDIZEM therapy is yet to be established.

OVERDOSAGE OR EXAGGERATED RESPONSE

Overdosage experience with oral diltiazem has been limited. Single oral doses of 300 mg of CARDIZEM have been well tolerated by healthy volunteers. In the event of overdosage or exaggerated response, appropriate supportive measures should be employed in addition to gastric lavage. The following measures may be considered:

Bradycardia	Administer atropine (0.60 to 1.0 mg). If there is no response to vagal blockade, administer isoproterenol cautiously.
High-Degree AV Block	Treat as for bradycardia above. Fixed high-degree AV block should be treated with cardiac pacing.
Cardiac Failure	Administer inotropic agents (isoproterenol, dopamine, or dobutamine) and diuretics.
Hypotension	Vasopressors (eg, dopamine or levarterenol bitartrate).

Actual treatment and dosage should depend on the severity of the clinical situation and the judgment and experience of the treating physician.

The oral/LD_{50}'s in mice and rats range from 415 to 740 mg/kg and from 560 to 810 mg/kg, respectively. The intravenous LD_{50}s in these species were 60 and 38 mg/kg, respectively. The oral LD_{50} in dogs is considered to be in excess of 50 mg/kg, while lethality was seen in monkeys at 360 mg/kg. The toxic dose in man is not known, but blood levels in excess of 800 ng/ml have not been associated with toxicity.

DOSAGE AND ADMINISTRATION

Exertional Angina Pectoris Due to Atherosclerotic Coronary Artery Disease or Angina Pectoris at Rest Due to Coronary Artery Spasm. Dosage must be adjusted to each patient's needs. Starting with 30 mg four times daily, before meals and at bedtime, dosage should be increased gradually (given in divided doses three or four times daily) at one- to two-day intervals until optimum response is obtained. Although individual patients may respond to any dosage level, the average optimum dosage range appears to be 180 to 240 mg/day. There are no available data concerning dosage requirements in patients with impaired renal or hepatic function. If the drug must be used in such patients, titration should be carried out with particular caution.

Concomitant Use With Other Antianginal Agents:

1. **Sublingual NTG** may be taken as required to abort acute anginal attacks during CARDIZEM therapy.
2. **Prophylactic Nitrate Therapy**—CAROIZEM may be safely coadministered with short- and long-acting nitrates, but there have been no controlled studies to evaluate the antianginal effectiveness of this combination.
3. **Beta-blockers.** (See WARNINGS and PRECAUTIONS.)

HOW SUPPLIED

Cardizem 30-mg tablets are supplied in bottles of 100 (NDC 0088-1771-47) and in Unit Oose Identification Paks of 100 (NDC 0088-1771-49). Each green tablet is engraved with MARION on one side and 1771 engraved on the other. CARDIZEM 60-mg scored tablets are supplied in bottles of 100 (NOC 0088-1772-47) and in Unit Oose Identification Paks of 100 (NOC 0088-1772-49). Each yellow tablet is engraved with MARION on one side and 1772 on the other.

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Presented here are the basic descriptive statistics of the population of physicians who have been evaluated and treated from the Program's inception in 1974 through 1984.

Characterization of Georgia's Impaired Physicians Program Treatment Population: Data and Statistics

KARL V. GALLEGOS, M.D., and MERRILL NORTON, R.PH., *Atlanta**

HISTORICALLY, THE PRECISE characterization of the impaired physician has been limited by a number of factors: population studies have been small, information has been obtained from patient recall and has been difficult or impossible to validate, selection of the appropriate comparison groups has been difficult, and close follow-up of physician-patients for long periods after treatment has not been maintained.

Many of the unique aspects of the Medical Association of Georgia's Impaired Physicians Program (IPP) have solved some of these problems. Presented here are the basic descriptive statistics of the population of physicians who have been evaluated and treated from the Program's inception in 1974 through July 1984.

The logical first step in identifying a disease is to know and understand as much as possible about the frequency distribution of characteristics of the diseased population. The goal of this paper is to provide information that might assist in the recognition of fellow physicians with the disease of chemical dependence. Early recognition and appropriate treatment have been proven to be the most effective tools for preventing the more destructive and chronic phases of the disease. Eventually, a statewide recognition surveillance system may evolve to help identify physicians afflicted with this disease, which is the major occupational hazard of the profession. Without a working knowledge of the salient signs and symptoms of the disease, however, afflicted colleagues will continue to go untreated and pose problems for their profession, families, and patients.

Data have been presented on a variety of factors among the cases, in the hope that etiologic clues worthy of further study will emerge. The primary purpose is to provide general information for the practicing physician. The three major topics addressed in this article are: 1) General demographic characteristics of the study population; 2) Their professional activity, licensing, and legal status at the time of treatment; and 3) Substance abuse patterns.

Methods

Study Population

The population consisted of all 675 physicians evaluated and/or treated by the Medical Association of Georgia's Impaired Physicians Program from 1974 to July 1984. A total of 660 patients were United States citizens, representing 35 states. Thirteen were from Canada, one from the United Kingdom, and one from Brazil.

Demographic Data

Selected variables gleaned from each patient's chart are presented in Table 1. This information was obtained from the patient at the time of the initial

* Dr. Gallegos is Director, and Mr. Norton is Associate Director, Division of Data and Statistics, Impaired Physicians Program, Medical Association of Georgia. This research was funded by a grant from M.A.G. Mutual and the Medical Association of Georgia. Send reprint requests to Dr. Gallegos, MAG, 938 Peachtree St., NE, Atlanta, GA 30309.

TABLE 1 — Demographic Characteristics of the Impaired Physician Population, MAG Impaired Physicians Program, 1974-1984

Number of Physician Patients:	*675*	
Age in Years		
Mean	45.1	
Standard Deviation	11.35	
Range	(24-80 years)	
Sex	*Frequency*	*Percent*
Male	650	96.3
Female	25	3.7
TOTAL	675	100.0
Race		
White	649	96.1
Black	16	2.4
Other	10	1.5
TOTAL	675	100.0
Marital Status		
Married*	447	66.2
Divorced*	110	16.3
Separated*	54	8.0
Single	44	6.5
Widowed	20	3.0
TOTAL	675	100.0

* 83% report severe marital discord.

interview. The variables include age, sex, race, marital status, and the presence or absence of marital discord.

Patterns of Substance Abuse

These variables as shown in Table 2 allow the investigation of dose-effect relationships and are leading to new insights into the nature of chemical dependence in physicians. The variables presented include the number of drugs used; the primary, secondary, and tertiary drugs of choice; the route of administration; and the number of previous treatments. This information was obtained from the patient when presenting for evaluation of treatment. Only 659 patients had a substance abuse history. The remainder (N = 16) were not chemically dependent.

Results

The IPP has grown continuously from four physicians in the program in 1975 to 116 in 1983. This total number will be surpassed by the end of this year. The mean age has decreased from 51.3 years in 1975 to 43.3 in 1984. There have been 650 male and 25 female physicians evaluated and/or treated. The population was predominantly white (96.1%), there were 16 (2.4%) blacks, and 10 (1.5%) with other ethnic backgrounds. A total of 447 (66.2%) were married, and 110 (16.3%) were divorced. Of those either married, separated, or divorced, 83% reported severe marital discord (Table 1).

TABLE 2 — Classification of Substance Abuse Patterns in Impaired Physicians (N = 659), MAG Impaired Physicians Program, 1974-1984

	Frequency	*Percent*
Number of Previous A&D or Psychiatric Treatments		
None	210	31.8
Outpatient only	91	13.8
1	136	20.6
2-4	192	29.2
5-6	21	3.2
>6	9	1.4
TOTAL	659	100.0
Number of Drugs Abused		
Unknown	15	2.3
1	180	27.2
2-4	302	45.8
5-7	131	20.0
>7	31	4.7
TOTAL	659	100.0
Ten Most Frequently Abused Substances		
Alcohol	425	64.5
Meperidine	203	30.8
Diazepam	109	16.5
Amphetamines	82	12.4
Pentazocine	67	10.2
Oxycodone	57	8.6
Codeine	51	7.7
Cocaine	47	7.1
Marijuana	37	5.6
Morphine	35	5.3
Fentanyl	35	5.3
Route of Administration		
Oral only	345	52.3
IV and/or IM	34	5.2
Oral and IV and/or IM	220	33.4
Inhalants	4	0.6
Inhalants and Oral	15	2.3
All	25	3.8
Unknown	16	2.4
TOTAL	659	100.0

Some findings of the population study were that:

(1) Most physician-patients sought treatment in the IPP because of its reputation for success. A total of 449 (69.2%) had had some form of previous psychiatric and/or alcohol and drug treatment.

(2) The patterns of substance abuse within the population have changed over time. From 1974 through 1976 (N = 17), 76% used alcohol exclusively, in 1983 (N = 116), only 16 (14%) were pure alcoholics. The remainder used either a combination of alcohol and drugs, or drugs only. Associated with the increasing use of drugs, and with polydrug addiction, is the increased frequency of parenteral substance abuse. In 1984, only 24% of those treated to date were not intravenous or intramuscular substance abusers. About two-thirds of the population used alcohol. Meperidine and diazepam were the other drugs most commonly abused (Table 2).

Of the 675 physicians in the study, 33.2% had either lost their state license or their state license would be revoked if they did not enter treatment (jeopardy). A total of 24.5% had either lost their

DEA license or had license jeopardy. Of this population, 26.4% had criminal or legal problems other than state or DEA license problems, such as DUIs or felony charges (Table 3).

For comparison data, the Division of Survey and Data Resources for the AMA publishes annually *The Physician Characteristics and Distribution*. This document is a comprehensive resource for physician manpower data.

Table 4 shows perhaps some of the most important findings in the study of the impaired physician. Here, the IPP and AMA population of physicians have been compared for age, sex, specialty, and professional activity status. Interestingly, the IPP population is significantly different from the AMA population, with a $p<0.0001$ for each comparison made. Twenty-seven percent of the IPP group are in the age range between 50-59, compared with 17% for the AMA population. Fifteen percent of the IPP

TABLE 3 — Licensure and Legal Problems (N=675), MAG Impaired Physicians Program, 1974-1984

	Frequency	*Percent*
State License to Practice Medicine		
Lost	57	8.4
Jeopardy	167	24.8
OK	447	66.2
In Residency — No License	4	0.6
TOTAL	675	100.0
DEA License		
Lost	68	10.1
Jeopardy	97	14.4
OK	500	74.0
In Residency — No License	10	1.5
TOTAL	675	100.0
Criminal Legal Problems		
Yes	178	26.4
No	479	70.9
Unknown	18	2.7
TOTAL	675	100.0

TABLE 4 — Comparison of MAG Impaired Physicians Program (IPP) with AMA Population

	IPP Population		*AMA Population*
*Age Distribution**	*Frequency*	*Percent*	*Percent*
<30	43	6.4	10.9
30-39	219	32.4	30.9
40-49	163	24.1	21.1
50-59	180	26.7	17.0
60-69	59	8.7	11.4
≥70	11	1.6	8.7
TOTAL	675	100.0	100.0
Sex†			
Male	650	96.3	87.8
Female	25	3.7	12.2
TOTAL	675	100.0	100.0
Specialties — Ten Most Frequent‡			
Family Practice or General Practice	193	28.6	12.5
Internal Medicine	85	12.6	15.5
Anesthesia	70	10.4	3.5
General Surgery	45	6.7	7.1
Psychiatry	42	6.2	5.8
Ob-Gyn	39	5.8	5.6
Emergency	24	3.6	1.6
Pediatrics	22	3.3	6.1
Orthopedics	21	3.1	3.0
Radiology	19	2.8	2.0
Other	115	17.0	37.3
Status of Professional Activity§			
Practice Medicine	515	76.3	67.2
Resident	55	8.1	13.1
Not practicing because of chemical dependence‖	75	15.6	7.2
Retired‖	17		
Other‖	13		

* $X^2=95.5$ with 5 df; $p<0.00001$.
† $X^2=49.9$ with 1 df; $p<0.0001$.
‡ $X^2=166.2$ with 9 df (Excluding "other"); $p<0.0001$.
§ $X^2=59.9$ with 2 df; $p<0.0001$.
‖ Inactive.

sample were inactive (not practicing medicine) at the time of evaluation or treatment, compared with 7.2% of the AMA group. There appear to be ''vulnerable'' specialties that may have an increased risk for chemical dependence: Anesthesia, Family or General Practice, and Emergency Medicine. Drug availability, job stress, and boredom are believed by the authors to be aspects of these specialties that make individuals within their ranks at risk for chemical dependence.

Of the 675 physicians in the study, 33.2% had either lost their state license or their state license would be revoked if they did not enter treatment. . . .

Currently, a study is in progress of all physicians who completed full treatment in the IPP; that is, those who went through the 4 months of supervised treatment and who signed the contract for 20 months of aftercare in their community. Of the 250 physicians with the minimum requirement of 2 years since entering treatment, 73.9% reported complete abstinence (ranging from 2 to 10 years) at the end of the study. Several of those who did relapse shortly after treatment have ''gotten their act together'' (frequently without another admission) and are now back in their personal recovery program (Narcotics Anonymous or Alcoholics Anonymous). Consequently, a total of 77.3% reported a minimum of 2 years complete abstinence. These numbers most likely will change as research techniques improve. To date, 29 (11%) of the 250 have not been contacted and are counted as treatment failures.

Comments

Georgia's Impaired Physicians Program has grown. With this new growth, new patterns and findings are emerging that are beyond the scope of this discussion. Coincident with this growth comes the burden of change to meet these new challenges presented by the treatment population. Several salient questions arise. Of the questions demanding immediate attention, one is, why are there fewer women than expected coming in for treatment? And why are there so few ethnic minorities.

The characterization of the impaired physician is underway. Early information shows that the impaired physician group is different and not representative of the total physician population. There is hope that the ''vulnerable'' physician will soon be well characterized and with this characterization early recognition and intervention will lead to more effective treatment than presently available.

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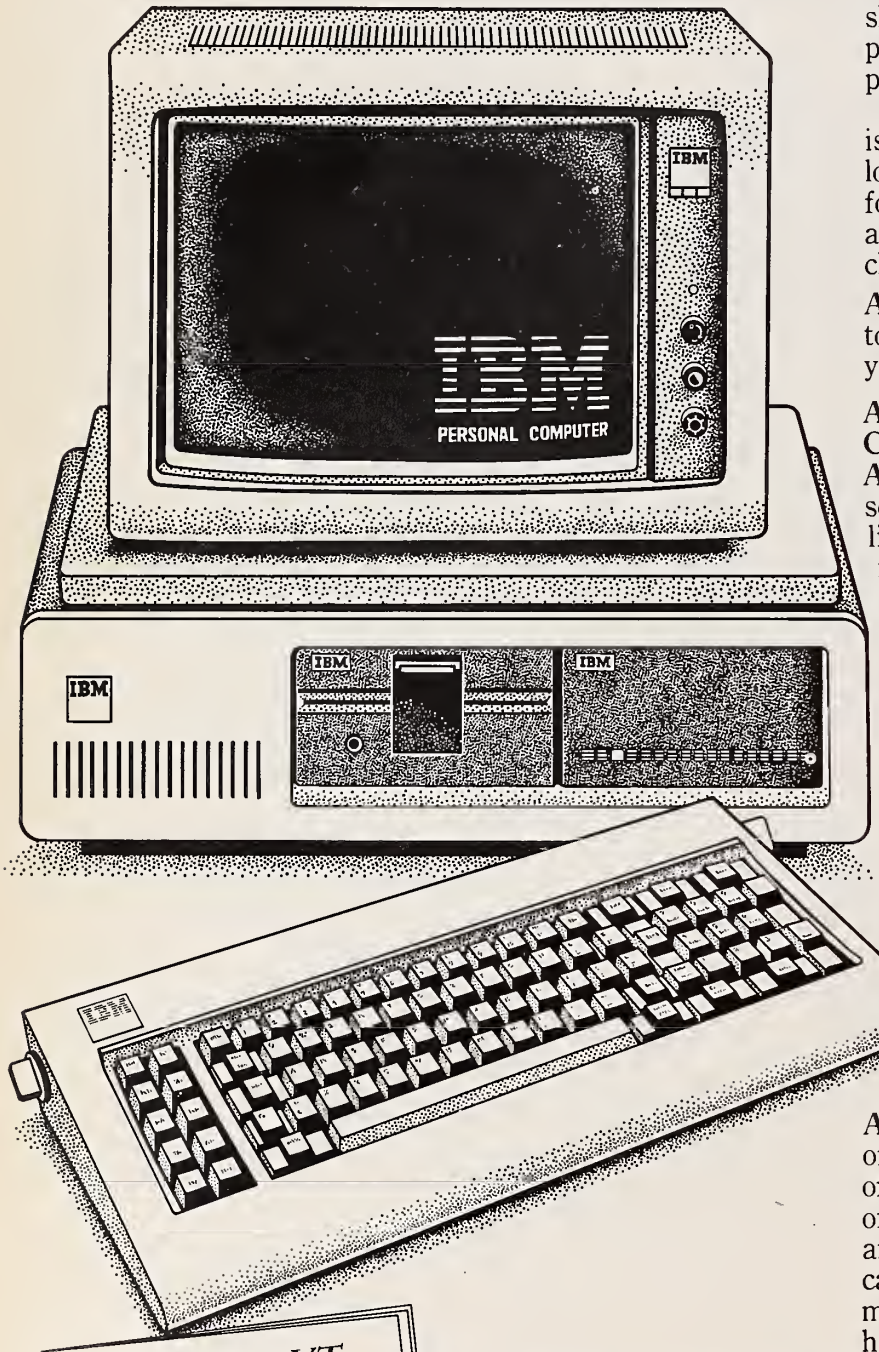
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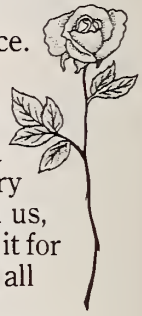
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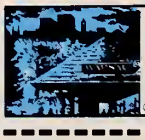
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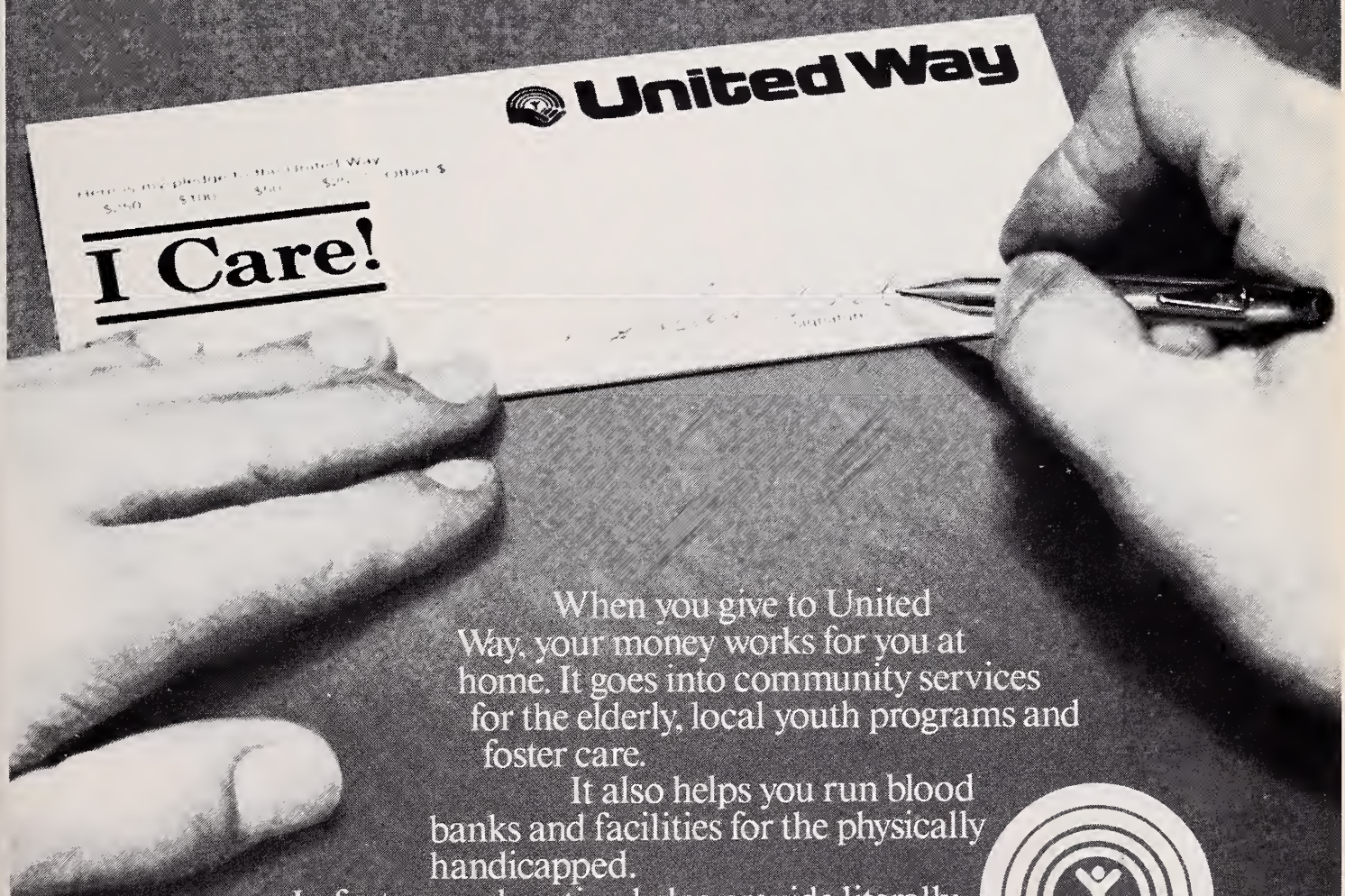
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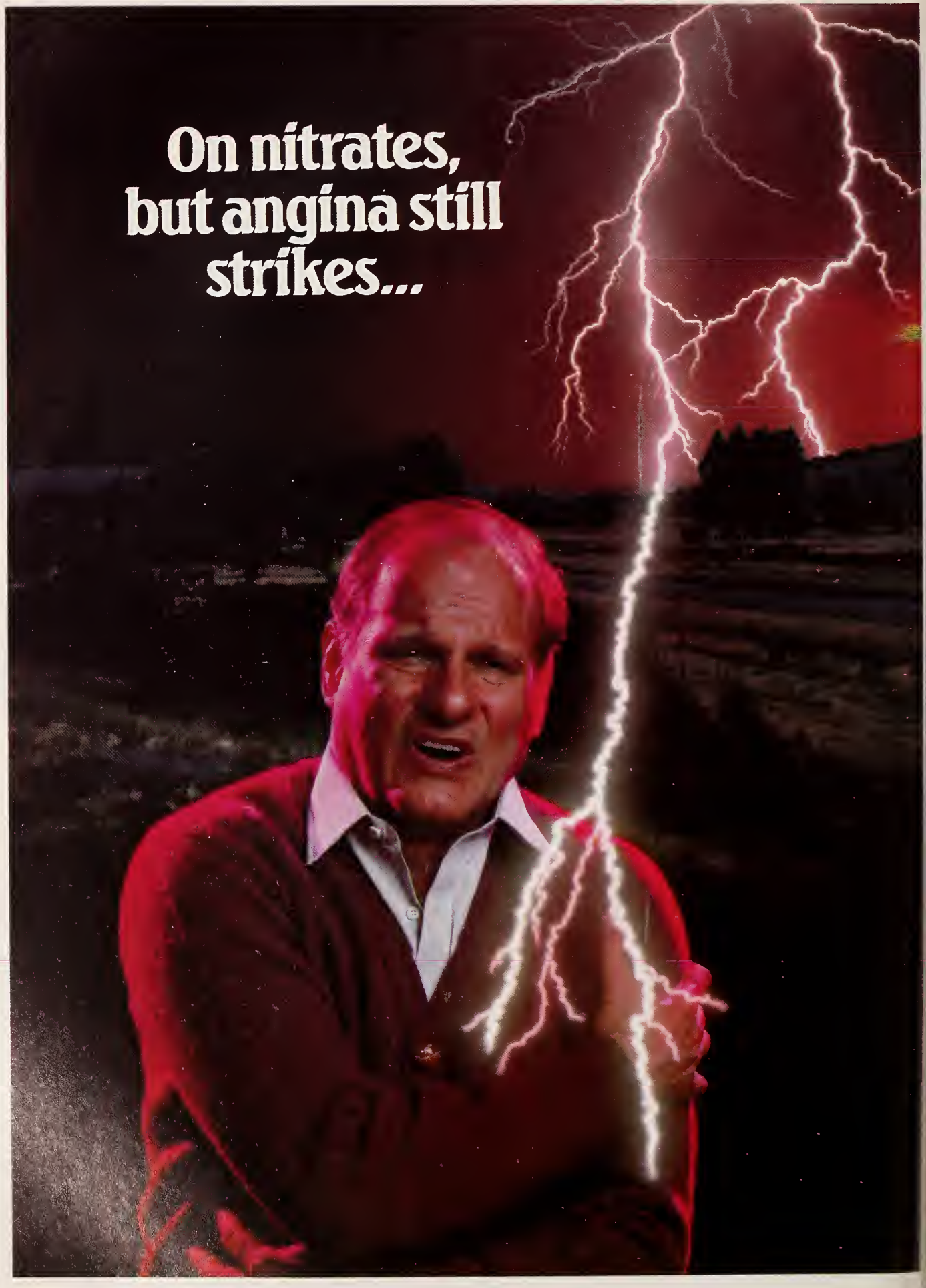
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Acknowledging having the disease [of chemical dependence] and surrendering to the treatment and lifestyle of recovery from the disease are difficult for most doctors and impossible for some.

Relapse and Recovery: Special Issues for Chemically Dependent Physicians

G. DOUGLAS TALBOTT, M.D., *Smyrna,* and CAROLYN ANNE MARTIN, PH.D., *Atlanta**

Relapse is a characteristic component of the disease of chemical dependence and is defined by the authors as resumption of the intake of mood-altering drugs following a recovery process. Relapse is a typical occurrence unless potentially contributing factors are recognized and addressed.[1] These "trigger mechanisms" are believed to be similar for most people with chemical dependence,[2] but some aspects seem exacerbated for people in medicine.[3-5]

The purpose of this article is to characterize factors believed to lead to relapse and to describe certain circumstances that increase the risk of relapse in people in the medical profession. In addition, suggestions are given for helping to prevent relapse as well as for using it to strengthen subsequent recovery if it does occur.

The remarks made in this article are derived from clinical observations of more than 665 physicians (and 335 other health professionals) who have completed Georgia's Impaired Physicians Program (IPP) over a 10-year period, as well as from findings of a recent unpublished follow-up study of 1977 and 1981 IPP cohorts (n = 109). Four patients (28.6%) in the 1977 group who completed the full 4-month treatment program (n = 14) relapsed before the 1984 follow-up interview. In the 1981 cohort, 12 of the 62 patients (19.7%) relapsed. Of those patients, who in addition to undergoing full treatment also fulfilled the terms of the 20-month contingency aftercare contract, only one relapsed prior to follow-up. The time of greatest risk for relapse is the first 2 years after entering treatment. This, of course, is the rationale for having the initial 1-month intensive treatment phase and the 3-month extended outpatient and work phase followed by the lengthy aftercare period for this population.[6] The IPP Caduceus Club forms a network for interrupting relapse when it does occur and helps physicians return quickly to the terms of the aftercare contract. In the study cited above, six physicians did return to the IPP recovery regimen following relapse and had completed 2 years of abstinence at the time of the follow-up interview.

Factors Contributing to Relapse

Lack of Acceptance of Chemical Dependence as a Disease

The fundamental factor which is believed to precipitate relapse is a failure to understand and accept the disease precept of chemical dependence. The term precept is used to indicate that clinical experience, research data, and animal-cellular experimentation all have contributed evidence toward substantiating the belief that chemical dependence is actually a disease, not merely a useful theoretical category.[7]

Chemical dependence has been shown to exhibit a general, though variable, symptomatology, to have certain biogenetic, psychosocial components, and to follow a generally predictable course leading to death, if untreated.[8] That chemical dependence is a disease is the basic assumption of this paper and is considered axiomatic for all practical purposes. Alcoholism and other drug addictions are considered as slight variations of the same disease.

The acceptance of this precept may be a matter of life or death for people with the disease. If people

* Dr. Talbott is an addictionologist and Program Director of MAG's Impaired Physicians Program; Dr. Martin is a counseling and consulting psychologist and Editorial Director of Research for the Impaired Physicians Program. Send reprint requests to Dr. Talbott at 3985 South Cobb Dr., Ste. 210, Smyrna, GA 30080.

who are chemically dependent do not accept their condition as a disease, then in their minds there is no reason to abstain from mood-altering drugs and the disease will become active again. Of all people, it would seem on the surface that physicians would readily accept this disorder as a disease; however, it has been our experience that the majority do not. All too often, we have found them to be more resistant to such classification than other people. There are several reasons for their reluctance. Until very recently, little information on alcoholism and drug addiction was presented in medical training, except for discussion of complications to the various organ systems involved in the last stages of the disease. Little or nothing was taught about the diagnostics or dynamics of the disease.

The emotional and physical traps of hunger, anger, loneliness, fatigue, and self-pity have been defined by the recovery community through the years as key factors in relapse.

Secondly, the culture in this country still does not regard alcoholism and drug addiction as a disease but views it at best as a matter of poor taste and at worst as a moral or psychologic problem. Physicians are products of their culture and tend to hold similar beliefs to those held by the rest of society.

Thirdly, the variety of symptoms of chemical dependence which may or may not appear in different combinations in any individual case makes it difficult for people to conclude on their own that they have chemical dependence. Even the compulsion to use is not present all the time. Many people can stop using; they just can't stay stopped. Thus, the nature of the disease itself, with its variety of signs and symptoms, contributes to the confusion[9] and to the lack of acceptance of the precept. The disbelief, then the fear, disgust, and moral indignation of people in the family[10] and community who do not understand chemical dependence certainly add to the confusion of people who have the disease.[11]

Finally, before Prohibition, American physicians treated alcoholism as a disease, but since Prohibition, the culture has considered chemical dependence a bad habit due to immorality or a weak will.[12] Physicians are products of their culture and currently many find it difficult to accept the definition of chemical dependence as an illness. The American Psychiatric Association,[13] World Health Organization,[14] and various addictionologists[8, 15, 16] have presented definitions establishing alcoholism and other drug addictions as biogenetic, psychosocial diseases. Although chemical dependence is similar to diabetes in some respects, the attitudes regarding relapse in these two diseases are quite different. We have yet to hear emergency room health professionals say to a returning patient, "Not again, you dirty diabetic!" Yet we have heard similar remarks used with a relapsing alcoholic or drug addict on several occasions.

Denial

Denial is another important contributing factor to relapse. It involves lack of acceptance of the disease on a personal, emotional basis, rather than a cognitive level. It involves failure to make the connection between abusing mood-altering chemicals and the problems which follow. People, therefore, continue the same behavior pattern while expecting different results. Acceptance on this experiential level involves a person's having to make subsequent decisions about what to do with his or her life based on this acceptance.

Denial is used as a defense but it is more global in nature than that seen in neurotics. The dynamics of denial, while a mosaic of pharmacologic and emotional factors, derive from physical and emotional pain. The physical pain associated with the effect of mood-altering chemicals is coupled with the fear of powerlessness and with the need to believe one possesses self-discipline and thereby can control most things in one's life. This combination makes the disease with its compulsivity difficult to accept personally. Physicians' belief that the exercise of self-discipline leads to extensive control of the immediate environment has been reinforced since premedical school days. Acknowledging having the disease and surrendering to the treatment and lifestyle of recovery from the disease are difficult for most doctors and impossible for some. The dynamics of denial make it very difficult for impaired physicians to reach out for help, even if they overcome the denial of self-identification as an alcoholic or drug addict,[17, 18] nor are they likely to get help if they seek it. Bissell,[19] in a survey of male alcoholic physicians who had been abstinent at least 1 year, found that 77.6% of her interviewees had sought professional help for alcoholism, but that the M.D. they approached had not recognized alcoholism as the problem.

The majority of physicians still do not accept the disease concept of chemical dependence.

Initially, chemically dependent physicians use denial to deal with the painful dissonance caused by discrepancies "between mind and reality."[20] Discrepancies between the way people perceive events and what they believe about them versus the way situations really are form the basis for alienation.

One such discrepancy exists between physicians' knowledge of pharmacologic effects of drugs and their lack of personal acceptance of the process of addiction in their own lives. Another is seen between personal experience and knowledge of the results of chemical abuse and their compulsion to use chemicals anyway. Cognitive dissonance of this type, documented extensively by Festinger,[21] leads one to resolve the conflict or to defend against it with such mechanisms as denial.

Abstinence from mood-altering chemicals leaves a void which is believed to be biochemical, psychologic, and spiritual in nature.

After weeks or months of abstinence, denial may again become potent. Many physicians who have been through intensive treatment, including cognitive and experiential learning about the disease of chemical dependence, may still at some stage of recovery seduce themselves into believing that all of these facts and experiences they have learned no longer apply to them. They tell themselves that they can drink or use again and "control it this time." They believe they have learned enough to be appropriate, "like everybody else," but just the opposite may be true. The disease seems to progress even during abstinence, and many people in relapse do not make it back to treatment before they die.[22]

Family Illness

Another factor that contributes to relapse is the family system. Just as the dynamics of the family play a part in the progression of addiction, the same forces play a part either in recovery or relapse.[23] If the family understands and accepts chemical dependence as a disease, and if family members have a program of recovery for themselves, then the responsibility for sobriety and for spiritual development is appropriately returned to the person who is chemically dependent. This person, and not the family, is responsible for the outcome, and the family is then free to give support without ambivalence. If this appropriate assignment of responsibility does not happen, then the same enabling and dysfunctional behavior seen in the progression of chemical dependence recurs and can contribute to continual relapse.[24]

Dishonesty

In many instances, dishonesty is difficult to separate from denial. The dishonesty that occurs is not usually "cash register" dishonesty, but rather emotional variance from the truth. This appears frequently in extramarital affairs, questionable business or political deals, social misconduct, and lying about or breaking appointments. Alcoholics Anonymous early recognized this problem and stated that there were some unfortunates with the disease who could not recover because they were constitutionally incapable of being honest.[24] Impaired physicians who have gone through the IPP have identified honesty as one of the most critical components of their sobriety and recovery and one of the most difficult conditions to maintain.

Lack of a Spiritual Program

Lack of a spiritual program has also been cited frequently by physician-patients as a factor in relapse. The emphasis in recovery is spirituality, not a specific religion. The steps in the AA/NA spiritual program consist of acceptance of the disease, surrender to a higher power, work on removing personal defects of character, and service to others. The second step of AA states that individuals who recover are those who came to believe that a power greater than themselves could restore them to sane living. Without surrender to this force, alcoholics and drug addicts continue to try to recover by themselves and thus remain in control, isolated and sick. As a consequence, many of them experience relapse.

Cross Addiction

Cross addiction persists as a frequent contributor to relapse in impaired physicians and far too often to their unintentional death by overdose. Unlike the laymen who believe a doctor's prescription is inviolate and thus become addicted to prescription drugs, physicians know the pharmacologic effects of drugs they prescribe. Therefore, they often eschew prescription drugs but then resort to over-the-counter drugs and get into trouble as a result. Many drugs have unintended effects when combined with other drugs or with alcohol; they also have unintended results when tolerance level changes abruptly, as it does in the chemically dependent person. It is especially destructive if the physician, having identified narcotics as his or her drug of choice, then turns also to alcohol, pills, or marijuana to seek relief.

Stress

Stress in the form of job demands, marital/family discord, or emotional crises will often precipitate relapse. Initially, as well as in the early years of recovery, people who are chemically dependent do not have the capabilities, the tools, or the skills for dealing with stress nonchemically. Yet this is exactly what they have to learn to do to remain sober.

Emotional and Physical Traps

The emotional and physical traps of hunger, anger, loneliness, fatigue, and self-pity have been defined by the recovery community through the years as key factors in relapse. The slogans of "HALT" (which stands for "Don't get too Hungry, Angry, Lonely, or Tired") and "PLOM" (Poor Little Old Me) have been adopted by AA as admonitions to help avoid these traps that can lead to relapse. Physicians, because of the nature of their work, are often called on to delay meeting their basic physical and psychologic needs for an extended period of time. This delay can contribute to self-pity as well as to physical and emotional depletion and thereby contribute to thoughts of relapse and later to the relapse itself.

Isolation

Isolation, either in the form of physical isolation from others or staying away from the recovery community and its AA/NA meetings, can also precipitate relapse. Physical isolation, often called for by reason of physicians' professional duties, needs to be offset by contacts with family, friends, and the recovery community. When people stay away from meetings, they usually go back to friends and places associated with drinking or using days, and relapse soon follows. Such associations are particularly attractive and influential during the first few years of recovery. Abstinence from mood-altering chemicals leaves a void which is believed to be biochemical, psychologic, and spiritual in nature. That void must be filled with positive feelings associated with people and activities *in the present,* relationships and events that strengthen sobriety and spiritual development. Otherwise, the person seeks to fill the void with recalled feelings of euphoria associated with chemicals.

The dynamics of denial, while a mosaic of pharmacologic and emotional factors, derive from physical and emotional pain.

The nine factors described above are believed to contribute to relapse in people with chemical dependence. Certain circumstances have been noted which seem to increase the likelihood of relapse for physicians and other health care professionals. Obviously, the chances of becoming cross-addicted are better than average with physicians' ready access to drugs. A seemingly innocent use of a substance other than one's drug of choice can lead back to alcohol or to the abuse of other drugs (or a combination of the two). Drugs play an important role in physicians' treatment protocol for their patients, and physicians are known for their preference for self medication. These conditions contribute to their increased vulnerability to chemical abuse, leading to dependence.

The way to prevent relapse is to develop personal spiritual strengths along with nonchemical coping mechanisms for dealing with one's environment and accompanying feelings.

Another area of extra difficulty for physicians is related to control issues. Most physicians have a high need for achievement and control; they were selected for medical school on these dimensions; then their training reinforced and refined these characteristics. In their work, physicians are used to being in control of themselves and most other people around them, both ancillary personnel and patients, and they see their major task as eliminating or controlling pain and the disease process. It is, therefore, most difficult for them to give up control and to join others in fully accepting the "first step" of AA: "We admitted we were powerless over alcohol and that our lives had become unmanageable." The honesty expressed in this "step," however, is necessary for one to begin the process of recovery and to maintain it in the face of life crises that occur more or less to everyone regardless of chemical dependence. Physicians must deal with their patients' life crises as well as their own and consequently need a constant reminder of their inability to manage single-handedly.

Prevention of Relapse

Knowledge and acceptance of the relapsing nature of this disease, along with an attitude of cautious optimism regarding sobriety, form the basis for uninterrupted recovery, one day at a time. Chemically dependent physicians who become lax about going to meetings, cocky and confident about their "cure" or complete recovery, and diffident to the principles of recovery will begin to demonstrate in their daily living the various precipitating factors of relapse.

Prevention of relapse begins with the continual awareness of the possibility of this painful and often disastrous complication. The way to prevent relapse is to develop personal spiritual strengths along with nonchemical coping mechanisms for dealing with one's environment and accompanying feelings. A person thereby accumulates a reservoir of experiences in the successful use of these mechanisms and can draw on it in times of stress. In addition, he or she develops a network of supportive relationships for giving and getting compassion and help.

A blueprint for this kind of development is found in the "steps," the philosophy, and the structure of

AA and NA. Based on spiritual principles, the steps are concrete actions taken by people early in the program and followed by those to come later in the AA/NA fellowship. They are suggested as ways to enable people to chart their progress on the road to recovery. The philosophy teaches that perfect recovery is not attainable, but progress is. The structure of the AA/NA fellowship stresses democratic participation in the meetings and other activities and being of service to others. According to AA/NA literature,[25] the best way to keep sobriety is to give it away. Physicians completing treatment in the Georgia Impaired Physicians Program concur. They report in follow-up interviews that helping relapsing patients is often the most powerful prophylactic tool in the prevention of their own relapse. This process in IPP is called "mirror image therapy" and is a vital part of the extended outpatient phase of treatment.

How to Handle Relapse If It Does Occur

The primary characterization of the chronic disease of alcoholism and other drug addictions is compulsion to alter one's mood, and the method of choice is the use of chemicals. With the elimination of this one-dimensional coping technique for all situations, both victims of the disease and their families often fail to take note of the serious possibility of relapse. The resumption of chemical coping following a recovery process is a fairly common occurrence and, although not happily welcomed, must be honestly faced. In no way should confronting this issue be construed as permission or encouragement for relapse to occur. Rather, dealing with this possibility allows people with the disease and their families to acknowledge their ability to handle the event and gain proper perspective to use this experience, as any other, in the recovery process.

The IPP Caduceus Club forms a network for interrupting relapse when it does occur and helps physicians return quickly to the terms of the aftercare contract.

Addressing the issue that relapse is a frequent characteristic of the disease of chemical dependence, the Georgia Impaired Physicians Program formulated a document entitled "Relapse Guidelines." The formal procedure of having the patient, the counselor, and the primary monitoring physician all sign the Guidelines is part of the process of transition from treatment to reentry status. The title of the document was carefully worded to indicate the real possibility of a relapse's occurrence without suggesting its inevitability. The term "guidelines" rather than "contract" or "agreement" was selected to imply suggestions very much like road signs for missing potholes, for getting around obstacles, and for maneuvering detours on the road to recovery. In no way does signing this document give permission or encouragement for relapse to occur. Rather, it acknowledges the seriousness of such a possibility while at the same time suggesting that as cues and clues are picked up indicating that relapse is imminent, conditions can be neutralized as prescribed in the Guidelines, thereby preventing relapse. If, however, the signs are not perceived and relapse does occur, the Guidelines specify ways to deal with it constructively to get the patient and family back on track.

"Relapse Guidelines" address the three predominant systems involved in relapse and recovery: the patient, the family, and the primary monitoring physician. Suggestions for each system are included below.

Patient

Alcoholics Anonymous speaks of "stinking thinking" as the prelude to actual drinking and drugging. Dr. Martha Morrison echoed the AA/NA philosophy when she said, "I alone can do it, but I cannot do it alone, for isolation and aloneness are the assassins."[26] The chemically dependent physician has admitted to having thought of or planned a relapse before actually consuming the drug. This is true for most alcoholics and drug addicts. It is, therefore, recommended and even urged that if the desire or compulsion arises, the patient should take the following steps *before* using a chemical. Certainly, the steps need to be taken if one has already used a chemical. Patients are instructed to do the following:

1. Call your sponsor — every impaired physician should have a sponsor in AA or NA, and preferably should talk to that sponsor daily for the first 5 months of recovery. Call your sponsor *before* a drink.
2. Go to a meeting immediately and daily thereafter or more often if needed to resolve the conflict over "using."
3. Call AA/NA friends and share honestly with them either the urge or the incidence of using.
4. Contact by phone or in person your treatment center or primary addiction physician — discuss truthfully your addiction.
5. Admit and discuss in detail at the AA/NA meetings your compulsion or relapse.
6. Pick up the white chip at a meeting — begin again with the first step.
7. Talk with your spouse, family, and/or significant other. Although it may be difficult for them to accept your relapse, share it with them.

Family

If impaired physicians and their family members are committed to recovery, then they agree with the above guidelines and will utilize them as needed. Families and significant others are advised to do the following:

1. If you are aware of the relapse of your loved one before he or she talks with you about it, call your sponsor in Al-Anon/Nar-Anon and contact person at the treatment center.
2. Go to Al-Anon/Nar-Anon meetings daily; discuss the relapse and your feelings until you have resolved any conflict you have about the situation.
3. Detach from the patient with love and continue your life.
4. Reinforce your own recovery program through Al-Anon/Nar-Anon contacts and friends.
5. If your loved one tells you of relapse, listen openly, support the person, and turn the responsibility back over to him or her.
6. If the person does not admit and discuss the relapse, follow the advice of your sponsor and treatment center contact as to the possibility of intervention.

Primary Care Physician

If impaired physicians and their family members are committed to recovery, then they will use the above guidelines as needed and they will involve the primary care physician. When informed of an impaired physician's relapse, the primary care physician will assess the situation and make recommendations both to the patient and to the treatment center staff, who may deem it necessary to insist on additional hospitalization or treatment, or at least an immediate and frequent drug screen. Although it is not usually necessary, direct intervention in some cases can be life-saving. In most cases an interruption of relapse can be accomplished simply by implementing the guidelines presented above. Members of the physician's support system are contacted to offer support and enlist their cooperation to increase the probability of early interruption of the relapse.

Conclusions

Components of the disease of chemical dependence and factors of recovery are believed to be generally similar for people who suffer from chemical dependence; however, individual differences are present, and recognition of them is important in several ways. The drug of choice, route of administration, and the extent of medical complications may contribute to a different overall pattern of the disease. One's sex and ethnic background, as well as lifestyle and presence of a support system, may also modify one's pattern of addiction and response to treatment programs.

Furthermore, people in some occupational groups have been found to be especially resistant to treatment, such as physicians and other medical personnel. Part of their difficulty in maintaining sobriety lies in their personal and family background, in their training, and in their drug history. Another part certainly has to do with the ambience of their work environment and their traditional position in the community. A treatment program must be able to accommodate to these individual differences in order to foster patients' acceptance of the disease precept and identification with peers. Only then will channels of communication be in place for constructive confrontation and support. Of course, similar conditions are utilized in AA and NA through self-selection. People in AA/NA choose a "home group" with which they identify and which becomes their reference group. It provides support as well as confrontation for personal and interpersonal growth.

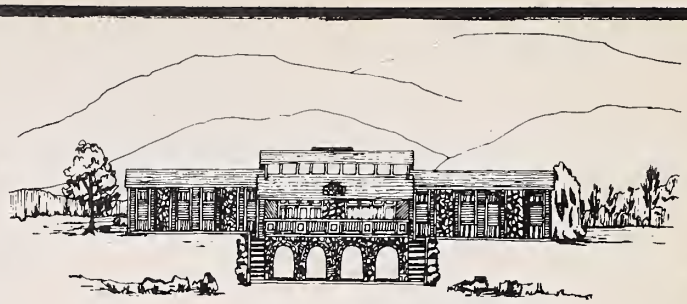
Knowledge and acceptance of the relapsing nature of this disease, along with an attitude of cautious optimism regarding sobriety, form the basis for uninterrupted recovery, one day at a time.

Relapse can either be a treatment failure or just another milestone on the road to recovery. Which will be the case depends on the attitudes and interactions of the patient and the family, the treatment personnel, and other support systems. Relapse is an ever-present possibility and as such is both universal and individual in nature. People recovering from chemical dependence learn which methods work best for them to deal with their life crises and with their "dry drunks" to ward off a "wet drunk" later on. The continual *process* of recovery is the important thing to remember.

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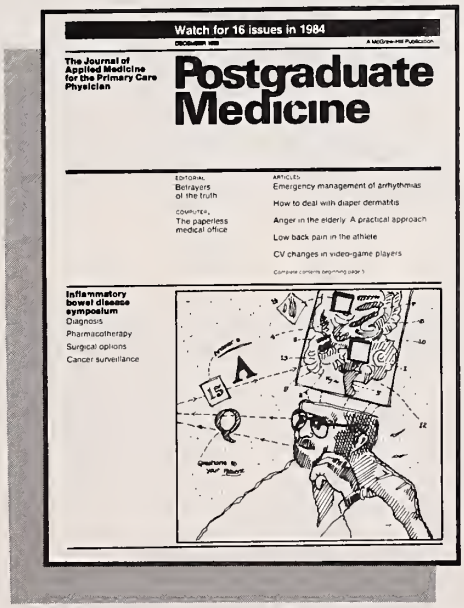
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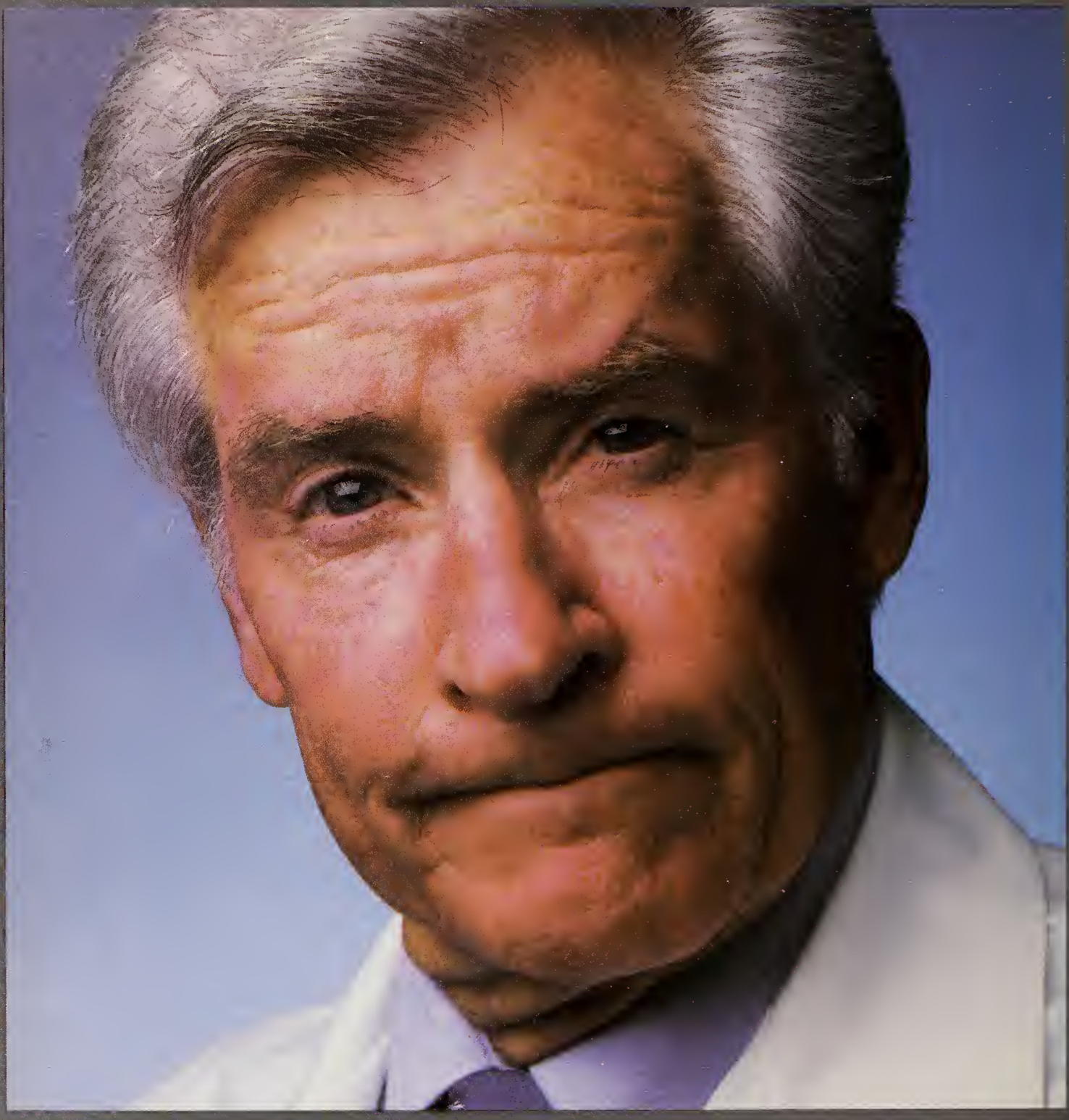
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Several weeks of detoxification and a great deal of confrontation are frequently required before individual patients are willing to understand that their lives and professional competence are indeed in jeopardy.

Dynamics in Group Process in Impaired Health Professionals

THOMAS E. BUTCHER, PH.D., *Atlanta*, and G. DOUGLAS TALBOTT, M.D., *Smyrna**

MEETINGS OF THE ENTIRE group of health professional patients has been a feature of the Georgia Impaired Health Professional Program from its inception. Initiated by the Medical Association of Georgia, this program has now been extended to include members from the Georgia Nurses Association, the Georgia Dental Association, and the Georgia Pharmacy Association. Despite divergent professional backgrounds, these impaired health professionals show the common characteristics of massive denial and inability to ask for help. These two forms of resistance are minimized in a very large group of health professionals. The notion that one cannot possibly have an addictive disease simply because one is a health professional is immediately countered by the presence of so many other health professionals with addictive disease. A group of this size is easily perceived as a source of help, whereas another individual or a smaller group could easily be seen as not being sufficiently powerful to provide the strength necessary for support.

Breaking Through Denial

The primary therapeutic operation of this large group is an integrative function, bonding the diverse elements of the treatment program, unifying them around the central goal of the program, and reducing fragmentation that occurs in a system with multiple therapeutic units. This group also allows opportunity for mirroring and for maintaining integrative and cohesive therapeutic dynamics, such as caring and identification with other members. The large group also provides the power necessary to reduce destructive or non-cohesive behavior, e.g., denial, rejection of treatment, relapse or sexual acting out, and entrance into and exit from the therapeutic milieu.

Without support of the large group, the degree of confrontation necessary to work through denial is experienced by the patient as damaging and hostile rather than supportive.

The central goal of the program is used as the theme for integrating the group at a conceptual level. That goal is to help physicians to recognize and personally accept their primary psychosocial-biogenetic disease of chemical dependency. The development of effective non-chemical coping skills is also an essential element of saving the lives and repairing the professional effectiveness of the patients. More often than not, patients first enter the treatment program in a massive state of denial. There is no conscious acceptance of the necessity for lifesaving maneuvers, and as far as most are concerned, there is no reason to suggest that their professional effectiveness is in the least impaired.

Frequently, there is strong rejection of any need for treatment. Physicians may acquiesce to treatment as a result of pressure from medical societies, loss of hospital privileges, or family pressure, but there is no awareness of how seriously their lives and professional competence are impaired. Several weeks of detoxification and a great deal of confrontation are frequently required before individual patients are willing to understand that their lives and professional competence are indeed in jeopardy. Without sup-

* Dr. Butcher is a Diplomate in Clinical Psychology; and Dr. Talbott is an addictionologist and Program Director of MAG's Impaired Physicians Program. Send reprint requests to Dr. Butcher, 1698 Noble Dr., NE, Atlanta, GA 30306.

port of the large group, the degree of confrontation necessary to work through denial is experienced by the patient as damaging and hostile rather than supportive. Reduction of denial is also enhanced by the identification possible in the large group. Meeting so many other people whose initial experience parallels that of one's own helps immeasurably in accepting the need for prolonged procedures to save one's life and to repair one's professional competence.

Aspects of Treatment

Sources of fragmentation in the 4-month treatment program, although essential, frequently act to reduce the cohesiveness of the patient community. Treatment is composed of a wide variety of groups with different levels of cohesion and different orientations. Weekly meetings of the large groups serve to reduce this fragmentation and identify the patient with the larger community. Patients in the large groups are from all stages of treatment — new patients still toxic meet with persons who have been in treatment 4-6 months and have recovered appreciably. The mirroring impact of the large group, showing older patients how they were when they initially entered treatment and showing new patients how they can hope to become as treatment unfolds, is a powerful influence on patients' identification with the treatment process.

In a group the size of the full physician-patient community, there is always someone else who has experienced the same thing any one given person has to hide. . . .

Both entry into and exit from treatment are important and difficult steps for patients to take. From the outset, entry involves a major change in the experience of living. One's identity is undergoing swift and massive alteration; one is no longer an independent, responsible, effective professional; and the fact that one has not functioned at this level for a very long time is repetitively impressed on one's awareness. The fact that one has a lifelong, life-threatening disease requires profound alteration of identity, and entrance into treatment is a clear step in the formation of this new identity.

Leaving the treatment process is no less difficult, for it is a return to an unprotected environment. One re-enters the same stresses and problems that were painful and leaves the therapeutic situation that is now seen as being primarily responsible for returning one to competent living. Re-entry is a process that very closely resembles the earlier experience of leaving home and making the very difficult beginnings of autonomy. Again, the mirroring effect of the large group is helpful at these major turning points. People leaving the program have an opportunity to see themselves as they were when they first entered, and people entering the program have an opportunity to see themselves as they may well become.

Therapeutic Dynamics of the Large Group

Maintaining integrative, therapeutic dynamics frequently has powerful unexpected therapeutic effects. On several occasions, the large group has confronted individual patients late in their treatment process. These patients fully accept the existence of their addictive disease but still present themselves as cold, aloof, isolated, and arrogant. All the efforts of smaller groups to penetrate this isolation have failed, yet when the large group insists upon maintaining its caring for these individuals even though they are unable to respond, the central problem is frequently seen as conflicts in the individual patient's own ability to care. Internal conflict related to their own caring for others lies concealed beneath the isolation. As their ability to experience caring for other group members is mobilized, the arrogant facade that had withstood intervention by individual therapists and by smaller groups dissolved. It was not too difficult for these patients to allow other people to care for them, but it was extremely difficult for them to allow themselves to experience their own caring for other people. As this emotional experience was mobilized in the larger group where there were so many persons that would stimulate caring, the apparent isolation dissolved very quickly. Support, encouragement, and concern with each other's welfare is a powerfully moving experience and increases each patient's concern for his or her own life and well-being. As one patient expressed it, "With so many people caring about you, it is impossible not to care about yourself."

This professional group has grown to include 80 to 90 members. Use of such a large group has frequently been questioned by those who are more familiar with the widely used, traditional, small group model. Use of this large group provides several unique therapeutic processes not available in groups with fewer members. First, alienation resulting from individuals' maintaining what is believed to be a unique secret can be handled very swiftly in a large group in contrast to a smaller one. In a group the size of the full physician-patient community, there is always someone else who has experienced the same thing any one given person has to hide, and there are always other persons who have experienced the same event from different perspectives. Uncovering this experience and allowing participants to work through all the different perspectives carries a powerful impact. Individual alienation is reduced, honesty is encouraged, and sharing with

other group members swiftly reduces alienating feelings. For example, a physician who felt himself responsible for a patient's death finds that secret to be a very heavy weight, alienating him from the rest of the medical profession. In this very large physician's group, there are always other physicians dealing with the same devastating secret, and the bonding that occurs as this is shared is a powerful therapeutic experience. Individual alienation is reduced in a way that is very moving to all participants.

Another therapeutic advantage that exists in the large group is the power of the group experience and its ability to sway individual opinion. This is an effective tool for reducing denial that, in health professionals, can be powerful enough to keep individuals immune to small group or personal intervention. Confrontation of denial can be handled with a swiftness and effectiveness in a large group situation seldom experienced in small groups. When one can see directly before one's eyes 80 to 90 persons who have also believed that they were the one person in 10,000 that was able to control drugs effectively, it is a little easier to admit to the dangerous level of self-deception in such a belief.

Confrontation of denial can be handled with a swiftness and effectiveness in a large group situation seldom experienced in small groups.

A group of this size is capable of generating a much more powerful experience of acceptance than is individual therapy or the traditional small group model. This acceptance is related to all phases of the program, from accepting the patient's first admission of his addictive disease to accepting the patient's competence to take the step into a more autonomous existence at the end of therapy.

In a group this size, it is as if all the significant people in a patient's history are available at the same time. At any point in therapy, the issues that are being raised can be dealt with at an incredibly rich variety of levels. One such issue is the repetitive experience that persons in the treatment program develop "heing and sheing" relationships with each other. These relationships are strongly discouraged during the treatment regimen as they detract from a person's ability to focus his entire energy on the treatment process. When they do occur, the opportunity to work through them in the larger group invariably stimulates intense therapeutic experiences in all the members. To see one's own pathologic relationships acted out in other people, to have available during the process of working through other persons who resemble father, mother, siblings, and other significant people provides opportunity for corrective experience at all sorts of levels simultaneously. In another instance, when persons are welcomed back into the group after a nearly successful suicidal attempt, it is as if they are being welcomed back into life by everybody that has ever been concerned with them. This is a very powerful and substantial experience of acceptance.

The mirroring effect of a group this size is more finely detailed and precise than in smaller groups. When new patients can see half a dozen individuals that are extremely intact and "together" leaving the program they get the distinct idea that there is something available that is beneficial. On the other hand, when a person leaving the program can see half a dozen other people entering disheveled, disoriented, and confused, he or she leaves thoroughly convinced of the power of addictive disease to destroy one's life.

Related to this mirroring effect is the frequent discovery that there is no personal event that is so unique that it is not shared by one or another of the group members, either from the individual patient's perspective or from the perspective of other persons who participated in the event. Any sort of traumatic occurrence, no matter how unique, can be worked with from every aspect, and this tool is simply not available in smaller groups. For example, health professionals with addictive disease have frequently been raised in families where addiction was rampant. As these professionals invariably start life with some outstanding abilities, they are frequently elected family rescuer and have had to function in ways that placed upon them the responsibility for the family's survival. Accepting this role locks them into methods of caring for other people in ways that reduce their own capacity to take care of themselves. The reorganization necessary to begin caring for themselves is experienced as if what one had to do is to allow one's parents and siblings to die rather than help them survive. This is an extremely difficult process that is greatly enhanced in the large group situation as there are also numerous people in the group who have been raised in addictive families and were not placed in the role of parental rescuer. There are also a number of persons whose experience with being rescued is that it turns one into a victim. The large group provides an opportunity to work with these varied aspects of experience in the immediate, ongoing therapeutic situation and allows members in the group to explore reactions in their experiential counterparts that frequently have never been available to them before.

Procedures for Group Leading

Procedures for leading the group are directly related to the integrative function. Groups are begun by asking members to introduce themselves, allowing each individual at the outset to experience an

entry process and to bring his or her own personal presence into the group. When time allows, this process is expanded to encourage each person's sharing a bit of their immediate personal feeling as well as something personal about themselves. The therapist maintains constant awareness of the strength of integrative dynamics and returns to processes which strengthen these dynamics whenever the level of conflict or confrontation reaches such intensity as to remove these dynamics from operation. For instance, the level of caring in particular is maximized and confrontation that does not include a powerful component of caring is minimized until such time as the level of caring is restored. Handling of personal issues in the group is managed so as to involve as fully as possible other group members with frequent checking to see which individual personal issues affect members of the group and how it does so. Restatements of the group purpose and the goal of saving lives and restoring professional competence is used whenever relevant. Occasional references to group opinion also serve an integrative function, identifying those members with common beliefs or reactions to individual situations and showing the individual patients how they stand in regard to their own level of integration with group opinion. Spontaneous dialogue and interruptions are encouraged, while personal attack and obscene language are discouraged. Questions exploring the possibility that others in the group may have shared whatever issue is being discussed are frequent. Patients who recognize similar experiences in themselves are encouraged to share these experiences with the group.

Dealing With Troublesome Patients

There are two particularly troublesome kinds of patients who find the large group meetings almost irresistible. Dominating, interrupting patients, operating so as to take over leadership of the group and the divisive, revolutionary patient who finds it necessary to mobilize the community against the treatment program are frequently seen in the physicians' group. These patients find the large group meeting irresistible as a sort of forum in which they can act out their conflicts. Such people occasionally exert considerable influence on others around them, but their own lives are almost invariably in serious jeopardy. The large group is an excellent modality for therapeutic intervention with these persons. Frequently simple questioning of other group members can encourage others to intervene with such disruptive patients. Questions as simple as "Let's check out with other group members how they stand and what their feelings are about what is happening" can disrupt one particular individual's manipulation of the group. The simple mechanical problem of going around briefly to everyone in a large group disrupts the focus that problem patients have been able to attain, and frequently there is strong resistance by other patients whose orientation to the treatment program is different from that of the problem patients. Such troublesome individuals are thus not able to control the ongoing group experience long enough to exert their full destructive influence and frequently the clear, "out in the open in front of everybody" reaction to what they are doing stimulates the disruptive patient to take a look at themselves realistically.

The mirroring effect of a large group is more finely detailed and precise than in small groups.

Groups of this size are not frequently used by group therapists, and their use is generally discouraged by those accustomed to working with groups of seven or so members. Experience with using these groups at the Medical Association of Georgia's Impaired Professional Program demonstrates that these groups can have a very powerful therapeutic impact in a wide range of essential therapeutic areas. It is hoped that the success of the Georgia experience will encourage others in a similar position to explore use of this therapeutic modality.

The author reviews the differential diagnoses of chemically dependent physicians who received treatment through MAG's Impaired Physicians Program.

Chemical Abuse/Dependence: Physicians' Occupational Hazard

MELVIN M. UDEL, M.D., M.P.H., *Smyrna**

THERE ARE CERTAIN characteristics specific to medical practice that make physicians vulnerable to disorders of chemical abuse and the disease of chemical dependence. These can be grouped as: (1) Factors that derive from the nature of medical practice; (2) The personality of the physician; and (3) The genetic-biochemical vulnerability of the physician. I will discuss the first two groups in this article.

The Features of Medical Practice

Physicians are in a unique bind as they strive to function as effective health service providers in our society. They are the focus of demands from the community (lay and professional), from family, and from those that are self-imposed.

The community imposes a number of constraints and expectations upon the physician. These include social and professional behavior, such as integrity; ethical behavior; and competent knowledge and skill. Even greater demands are the expectations of patients who want their physicians to be omniscient and omnipotent, compassionate and caring. Such attitudes can be seen as motivators in the healthy positive sense. They can also be seen as inordinate pressures insofar as these expectations go beyond practicality in today's era of super-specialization.

The family makes its own demands. The physician must be husband/wife, lover, father/mother. Demands are made on physicians' time, their emotional support, their involvement in family life and planning, and their creativity, and leadership. At the same time, the family identifies with the physician's objectives for success in practice, for recognition among peers, and for a place in the community. The family necessarily must accept a certain degree of deprivation of the physician's time, emotional support, and involvement. Inevitably, there is a price to pay.

Physicians bring their own expectations to the practice. These are ambition for academic achievement, peer recognition, social position, financial reward, a personal sense of self-esteem and achievement, and the understanding, devotion, and support of the family.

Generally, these three forces run parallel and tend toward an effective adaptation in life. However, inherent are certain conflicting forces, such as demands on time and attention, ability to maintain professional knowledge and skills, and participation in family and professional life — all of which can lead to stress. The physician must resolve this in some adaptive way, and always there is a trade-off. Most often, this is reasonably and effectively handled; but where it is not, we see the phenomenon of "dystress." The disorders of dystress run the spectrum from "burn-out" through the minor or moderate emotional problems through the psychophysiologic disorders all the way to ultimate disaster, such as disabling illness or death.

The Personality of the Physician

Sir William Osler is quoted as stating, "The personality of a patient with a disease is more important than the disease the patient has." Personality (ego strength) and cognitive function (intelligence capability) are essential features in adapting to the pressures of medical practice as defined above. Dr. George Vaillant[1] makes the general statement that emotional disorders do not produce chemical de-

* Dr. Udel is psychiatric consultant to MAG's Impaired Physicians Program. Send reprint requests to him at 3985 S. Cobb Dr., Ste. 110, Smyrna, Georgia 30080.

pendence, but chemical abuse and chemical dependence do produce emotional disorders. This is consistent with our findings, but we do see that dystress does lead to chemical abuse and to chemical dependence where there is a genetic-biochemical vulnerability to the disease.

Whenever one fails to deal effectively with the stressor, one experiences uncomfortable feelings and tries to relieve these feelings. As a physician, one of the first avenues of relief can be self-medication, this despite the dictum that physicians should never treat themselves. This is probably the most common route to chemical abuse and chemical dependence that we have seen in our review of hundreds of cases of impaired physicians.

. . . emotional disorders do not produce chemical dependence, but chemical abuse and chemical dependence do produce emotional disorders.

There are certain other characteristics that contribute to the physician's occupational vulnerability. These include: (1) ready availability of drugs, easy access; (2) lack of education, adequate understanding of chemical dependence; (3) the Titanic Syndrome (the physician is unsinkable), he/she is familiar with drugs, can comfortably self-medicate symptoms, where others cannot; (4) the "M. Deity" Syndrome (the physician is unique, special), he/she can handle stress, swallow painful feelings, and has no need to share. All of these exist in an atmosphere of a "conspiracy of silence," a mutual complicity in denial.[2] There is little wonder we see some severe pathology.

Since 1979, it has been my privilege to be psychiatric consultant to MAG's Impaired Physicians Program. During those 5 years, I have had the opportunity to psychiatrically evaluate, and in some cases treat, 551 physicians. One major function of the psychiatrist of the Impaired Physicians Program is to conduct a differential diagnosis of physicians as they first present for treatment. It is important to sort out those patients who have a psychiatric disorder that requires management prior to the treatment process for chemical dependence. Having done this, it is then appropriate to do a differential diagnosis to determine which patients have concurrent psychiatric disorders that are obstacles to appropriate treatment and recovery. From January 1980 to June 30, 1984, we evaluated 551 consecutive cases. Our findings are presented in Tables 1-5 that follow.

Table 1 shows a review of 100 consecutive cases of chemical dependence evaluated between January 1980 and March 1981. In 94% of these cases, the symptoms of chemical dependence were the primary, urgent presenting disease. Six percent showed intense primary psychiatric problems which needed to be dealt with first. We could not treat their chemical dependence until we first dealt with these psychiatric problems.

TABLE 1 — Review of 100 Consecutive Cases of Chemical Dependence Among Physicians, By Primary Diagnosis, January 1980-March 1981, Ridgeview Institute, Smyrna, Georgia

Total 100 Consecutive Cases (180-381)		
I. Primary Diagnosis		
A. Chemical Dependence		
Alcohol		35
Drugs		24
Mixed (Alcohol & Drugs)		35
	Subtotal	94
B. Psychiatric		
Depressive reaction		2
Organic brain syndrome		3
Borderline personality		1
	Subtotal	6
	TOTAL	100

TABLE 2 — Review of 100 Consecutive Cases of Chemical Dependence Among Physicians, By Secondary Diagnosis, January 1980-March 1981, Ridgeview Institute, Smyrna, Georgia

Total 100 Consecutive Cases, Continued:		
II. Secondary Diagnosis		
Personality disorder		34
Depressive reaction		28
Organic brain syndrome		7
Anxiety reaction		1
Mixed neurosis		2
Manic-depressive		1
Sexual dysfunction (does not include homosexuality)		1
	Subtotal	74
No significant psychiatric disorder		26
	TOTAL	100

A further aspect of differential diagnosis is to establish the secondary diagnosis. In chemical dependence, it is important to know the character structure of the patient and whether there are any complicating psychiatric factors present that will intrude on the treatment program or the subsequent recovery.

Table 2 shows that 74% of the patients had a secondary psychiatric diagnosis. The diagnosis was based on the prominent presenting clinical picture. There were 34 personality disorders and depressive reactions in 28 of the 74 cases. These depressed people also had an underlying personality disorder, but the diagnosis was not always apparent. Twenty-six percent showed no significant psychiatric disorder, which is important. Among the personality disorders, overwhelmingly the most prominent one

TABLE 3 — Diagnostic Review of Primary Diagnosis of 124 Cases of Chemical Dependence Among Physicians, March 1981-May 1982, Ridgeview Institute, Smyrna, Georgia

PSYCHIATRIC TRIAGE	
Primary Diagnosis	
1. Chemical Dependency	
a. Chemical Addiction (Drug)	42
b. Alcoholism	31
c. Poly drug dependence	35
Subtotal	108
2. Psychiatric	
a. Depression	1
b. Organic brain syndrome	5
c. Sociopathic	1
d. Borderline	1
3. Medical	1
4. No Psychiatric disorder	7
TOTAL	124

TABLE 4 — Diagnostic Review of Secondary Diagnosis of 124 Cases of Chemical Dependence Among Physicians, March 1981-May 1982, Ridgeview Institute, Smyrna, Georgia

PSYCHIATRIC TRIAGE	
Secondary Diagnosis	
1. Personality Disorder	60
2. Depression	26
3. Organic Brain Syndrome	8
4. Anxiety Reaction	
5. Chemical Addiction	5
6. Other	7
7. No Diagnosis	18
TOTAL	124

TABLE 5 — Diagnostic Review of Breakdown of Personality in 60 Cases of Chemical Dependence Among Physicians, March 1981-May 1982, Ridgeview Institute, Smyrna, Georgia

PSYCHIATRIC TRIAGE	
Breakdown of Personality Diagnosis	
1. Antisocial	2
2. Obsessive Compulsive	25
3. Borderline	4
4. Passive/Aggressive	2
5. Narcissistic	4
6. Dependent	5
7. Mixed	15
8. Schizotypal	2
9. Atypical	1
TOTAL	60

is that of compulsivity. When you realize this is a very special population sample, a caveat is appropriate as far as generalizing from this particular population to a general population of chemically dependent people. Dependency appears, but we see it as a regressive adaptation to the illness, because this was seen early in treatment but disappeared in most instances as recovery progressed.

Table 3 presents the diagnostic review of 124 more cases covering a period from March 1981 to May 1982 and directly follows chronologically the last set of cases in Table 2. In this group of cases, all were diagnosed as having the primary disease of chemical dependence; some had the usual concurrent psychiatric symptoms. In the urgent clinical presenting sense, 108 of this series of 124 were considered to have presenting symptoms of a chemical dependency nature. Eight cases had concurrent psychiatric symptoms. One had an urgent medical problem as a presenting feature, and in 7 there was no significant psychiatric disorder. Among the chemical dependent cases, there was a further breakdown of chemical type: 42 were dependent on drugs; 31 on alcohol; and 35 on polydrugs (polydrugs can be almost any mixture). In the psychiatric group: 1 patient had depression; 5 organic brain syndrome; 1 antisocial personality disorder; 1 borderline personality disorder; and 1 had a severe medical problem.

Table 4 represents a further elaboration of the secondary or characterologic diagnosis. In this group, about half showed symptoms of a personality disorder, about one-fifth showed presenting symptoms of depression, personality type not identified. There were 8 who had acute organic brain syndromes which generally cleared as the patients progressed through detoxification and early phases of treatment. The 5 cases labeled chemical addiction were the same 5 whose primary presenting disorders were organic symptoms having to be dealt with first. There were 18 patients whose character or personality structure were not symptomatic.

Table 5 shows the breakdown of 60 personality disorder diagnoses and shows that compulsivity is the most characteristic of our patient population. The next largest group is the mixed personality disorders, for example, some compulsive traits, some dependency traits, some passive aggressive traits — those types of traits which when clustered comprise a personality. Note further that in the personality disorder group, dependent personality as a characterologic adaptive style was relatively low (5 cases).

A Review of Treatment Outcome

It is useful to review what became of the 100 cases listed in Table 1. Sixteen patients left the treatment program during the first 4 months, during Phases I through IV; 4 patients had sustained organic brain syndrome without much hope of reasonable recovery; 3 had personality disorders which seriously interfered with the treatment program, and they could not adapt; and 9 of the 16 became psychiatrically ill and could not complete those first 4 months. That is a significant number of cases, roughly 10% of the

total population, that developed psychiatric illness during the course of treatment. This aptly illustrates the absolute importance of having a psychiatric capability as part of the evaluation and treatment team. An incidence of 10% is of great significance and needs further specific attention.

Of the 9 patients who became psychiatrically ill, 2 were handled on an outpatient basis and 7 required psychiatric hospitalization. Of these 7, 4 returned to strong aftercare programs in their respective communities and have done very well; 1 patient returned home and committed suicide. He was identified as a paranoid schizophrenic, but this only appeared later, some time after withdrawal from medication. One patient who had a severe paranoid personality disorder could not handle the program and returned home to his community where he was indicted for homicide; 3 dropped out of the program and contact with them has been lost. The remaining 84 satisfactorily completed the 4-month program and returned to practice.

From the evidence presented in this paper, it is obvious that self-medication is a self-destructive, maladaptive response to stress. More effective methods are beyond the scope of this presentation and should be more thoroughly discussed in another issue. For brevity, it is useful here to review Dr. Gerald Caplan's formulations.[3] The responses to stress occur in four inter-related phases:

Responses to Stress

Phase I — Behavior that changes the stressful environment or enables escape from it.
Phase II — Behavior to acquire new capabilities for action to change the external circumstances and their aftermath.
Phase III — Intrapsychic behavior to defend against painful emotional arousal.
Phase IV — Intrapsychic behavior to come to terms with the event and its aftermath by internal readjustment.

All the common methods for managing stress can be subsumed under these phases. We are all urged to apply these to our own professional and personal lives, not simply to avoid distress but to enhance our pleasure in life.

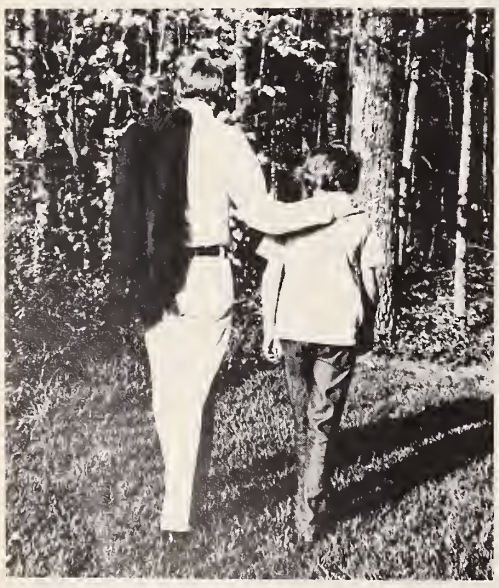
Acknowledgement

With gratitude, acknowledgement is given to Mrs. Gail McCollum, R.N., who performed the laborious task of tabulating this material.

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Gastrointestinal: Nausea,* epigastric pain,* heartburn,* diarrhea, abdominal distress, nausea and vomiting, indigestion, constipation, abdominal cramps or pain, fullness of GI tract (bloating and flatulence); **Central Nervous System:** Dizziness,* headache, nervousness; **Dermatologic:** Rash* (including maculopapular type), pruritus; **Special Senses:** Tinnitus; **Metabolic/Endocrine:** Decreased appetite; **Cardiovascular:** Edema, fluid retention (generally responds promptly to drug discontinuation; see PRECAUTIONS).

Incidence less than 1%—Probable Causal Relationship**

Gastrointestinal: Gastric or duodenal ulcer with bleeding and/or perforation, gastrointestinal hemorrhage, melena, gastritis, hepatitis, jaundice, abnormal liver function tests; **Central Nervous System:** Depression, insomnia, confusion, emotional lability, somnolence, aseptic meningitis with fever and coma; **Dermatologic:** Vesiculobullous eruptions, urticaria, erythema multiforme, Stevens-Johnson syndrome, alopecia; **Special Senses:** Hearing loss, amblyopia (blurred and/or diminished vision, scotomata, and/or changes in color vision) (see PRECAUTIONS); **Hematologic:** Neutropenia, agranulocytosis, aplastic anemia, hemolytic anemia (sometimes Coombs positive), thrombocytopenia with or without purpura, eosinophilia, decreases in hemoglobin and hematocrit; **Cardiovascular:** Congestive heart failure in patients with marginal cardiac function, elevated blood pressure, palpitations; **Allergic:** Syndrome of abdominal pain, fever, chills, nausea and vomiting; anaphylaxis; bronchospasm (see CONTRAINDICATIONS); **Renal:** Acute renal failure in patients with pre-existing significantly impaired renal function, decreased creatinine clearance, polyuria, azotemia, cystitis, hematuria; **Miscellaneous:** Dry eyes and mouth, gingival ulcer, rhinitis.

Incidence less than 1%—Causal Relationship Unknown**

Gastrointestinal: Pancreatitis; **Central Nervous System:** Paresthesias, hallucinations, dream abnormalities, pseudotumor cerebri; **Dermatologic:** Toxic epidermal necrolysis, photoallergic skin reactions; **Special Senses:** Conjunctivitis, diplopia, optic neuritis; **Hematologic:** Bleeding episodes (e.g., epistaxis, menorrhagia); **Metabolic/Endocrine:** Gynecomastia, hypoglycemic reaction; **Cardiovascular:** Arrhythmias (sinus tachycardia, sinus bradycardia); **Allergic:** Serum sickness, lupus erythematosus syndrome, Henoch-Schonlein vasculitis; **Renal:** Renal papillary necrosis.

*Reactions occurring in 3% to 9% of patients treated with *Motrin*. (Those reactions occurring in less than 3% of the patients are unmarked.)

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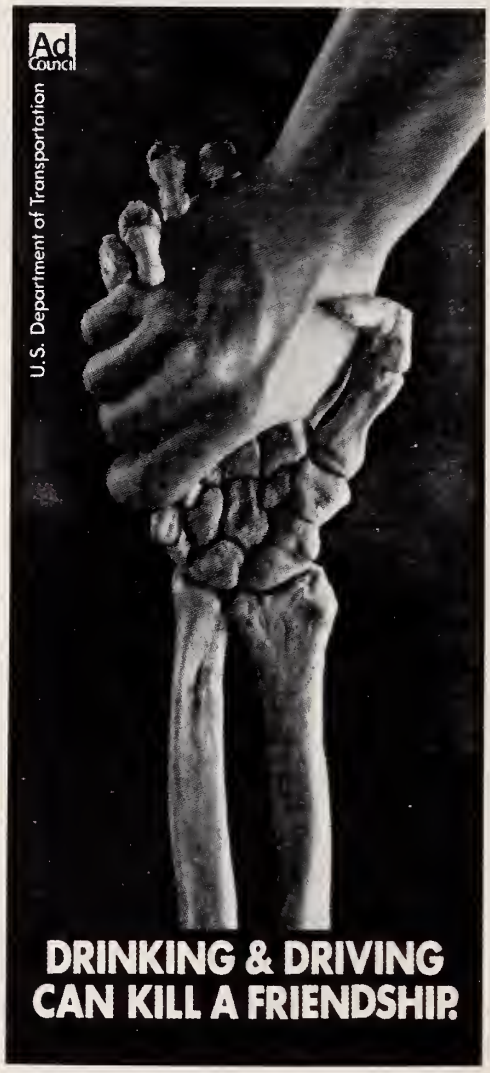
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J-4791 August, 1984



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An example of the "ripple effect" of a recovering impaired physician who initiated the development of support groups for health professionals re-entering hospital practice after treatment.

Hospital-Based Wellness Committee

EDWARD J. WAITS, M.D., *Atlanta**

Special Problems

STRESS, BURNOUT, ALCOHOLISM, drug addiction, and divorce are words all too familiar to us as physicians who care for our patients afflicted with these devastating problems. But what about us, our colleagues and their families, and our many helpers in the healing profession: nurses, pharmacists, and hospital employees? None of us are immune to these major maladies and stresses of the 80s.

The purpose of the Wellness Committee is to study ways in which we can better understand and deal with problems that gravely affect our professional and personal lives.

When these problems arose among the healing profession in the past, they were usually not dealt with in the hospital, by the medical staff or the administration. The problems associated with medicine were usually handled by some state medical committee or by disciplinary action of the State Licensing Board. This process was slow, and often ineffective, due mainly to the high level of denial by all concerned parties. Personal problems were ignored unless they became acute enough to compromise professional skills and thereby merit review and disciplinary action.

Early intervention, with care and support for the suffering health professional, was rare and usually misinterpreted as threatening. Obtaining treatment for psychiatric impairment or chemical dependence was stigmatizing and avoided whenever possible. Support groups for health professionals re-entering the hospital after treatment were non-existent.

Meeting the Needs of Impaired Health Professionals

At Northside Hospital over 18 months ago, we recognized the need for some means of dealing with these problems in our community of health professionals. We visited the Center for Well-Being of Health Professionals in Durham, North Carolina, and consulted with the director, Dr. John Henry Pfifferling. Dr. Pfifferling visited Northside Hospital and assisted us in the formation of our Wellness Committee. The primary purpose of the committee is to study ways in which we can better understand and deal with problems that gravely affect our professional and personal lives. Its primary emphasis is on education, prevention, early intervention, and support of all concerned.

The composition and activities of the Wellness Committee are varied. Representatives from the nursing staff, hospital employees, and the administration were invited to our meetings. This "mixed" membership has allowed our committee a new level of communication, thus forming a "network" of caring people throughout the hospital. Outside speakers, sponsored by the committee, periodically visit the hospital for a lecture and/or workshop related to impairment or wellness. At regular monthly meetings, the committee studies educational material on the disease of chemical dependency, wellness, intervention techniques, stress reduction, etc. Video-cassette tapes are shown at each meeting followed by a discussion period.

A "Hot Line" has been established for emergency confidential counseling available to all members of the hospital community. A counselor is "on duty" at a location convenient to the hospital for the purpose of taking emergency calls and seeing anyone

* Dr. Waits is a general surgeon and Chriaman of MAG's Impaired Physicians Committee. Send reprint requests to him at 960 Johnson Ferry Rd., NE, Atlanta, GA 30342.

for immediate emergency counseling. This service is offered at no charge. Anonymity and confidentiality are maintained at all levels.

The committee formed intervention teams which are non-threatening in composition. Peers help the impaired health professional accept his or her problem. They then offer options for treatment, help provide coverage of practice while the individual is in treatment, and give assurance of support at time of "re-entry." Individual committee members serve as "advocates" for health professionals re-entering the hospital after treatment.

A subcommittee negotiated with a local facility offering racquetball, swimming, and other indoor exercise facilities for a "free" membership to the hospital community on the condition that we promote physical fitness as part of our overall wellness program.

To summarize, the Wellness Committee at Northside Hospital has been meeting on a regular monthly basis for approximately 18 months. Our attendance has been comprised of physicians, nurses, pharmacists, hospital employees, medical auxiliary members, and hospital administrators, and has averaged approximately 14 people per meeting. There is also a weekly Al-Anon meeting averaging 10 people per meeting.

Our activities and services receive continuing publicity in our hospital newspaper and medical staff letter re-enforcing our existence to the entire hospital community. Members of our committee are often approached by individuals for advice and support concerning impairment of a family member or colleague. The image and posture of our committee continues to be one of support and concern for all members of the hospital community.

Finally, it should be emphasized that this concept is new. We are "sailing uncharted seas" so to speak. Our hope is to learn as we go and to share our experience with other hospital health professionals.

The guidelines listed in Table 1 have been adopted from those used by the California Medical Association to assist in forming Hospital Wellness and Impairment Committees.

Guidelines for Hospital Wellness Committees

Charges

1. To be the identified point within the hospital where information and concern about the health of an individual health professional can be delivered for consideration.
2. To receive and consider information; to seek corroboration and additional information.
3. To provide advice, recommendations, and assistance, including educational, therapeutic action, to the health professional in question and to the person or group who contacted the committee (the referring source).
4. To respond to the person or group who contacted the committee.
5. To educate its members and the members of the medical staff about the health, well-being and impairment of the health professional; about appropriate responses to different levels and kinds of distress and impairment; and about appropriate resources for prevention, treatment, and rehabilitation.

Composition (Membership)

1. Members should be selected for specific expertise, experience and willingness to serve. An effort should be made to appoint members from several specialties.
2. The policy of the committee should be to encourage terms of membership of several years, so as to provide for continuity and development of expertise.
3. A physician should not serve on both the hospital wellness committee and a committee which has review or authority over members of the medical staff.

Policies

1. The committee should be concerned primarily with the needs of the health professional in question.
2. The committee should have no authority to take disciplinary action. It should serve as an advisor to the referral source and to the health professional in question.

Reducing the Death Rate From Cancer

CHARLES M. HUGULEY, JR., M.D., *Atlanta**

THE NATIONAL CANCER INSTITUTE has recently set a goal of cutting the death rate from cancer in half by the year 2000. This goal is realistic and worthy of a strong national effort and of support by the medical profession, especially by the providers of primary care. The purpose of this communication is to explain the approach.

Primary Prevention

There are striking differences in cancer incidences within the same ethnic group in different geographic areas. For example, the Japanese in Hawaii have much higher rates of cancer of the large bowel and breast than in Japan, but a much lower rate of cancer of the stomach. In each instance, the rates among Japanese in Hawaii are similar to those among Caucasians (except liver and cervix). The incidences of most cancers are much higher among USA blacks than among Nigerians. Again, the rates in the USA are similar for blacks and whites. These findings, among many others, suggest that the major causes of cancer are not genetic but environmental and therefore potentially avoidable. A great deal of our current thinking about the prevention of cancer is based on a monumental review and analysis by the English epidemiologists Richard Doll and Richard Peto in 1980.[1]

If the incidences of each form of cancer in Connecticut are compared with the incidence of each form in the area of lowest incidence and the total cancer incidence in Connecticut (3365 per million per year) is then compared to the sum of the incidences in the low incidence areas (729 per million per year), we find that the potential reduction in incidence which could be achieved by manipulation of lifestyle is 78%.

Tobacco (The American Indian's Revenge)

There are good data to attribute over 90% of cancer of the lung to cigarette smoking, as well as 85% of cancers of the mouth, pharynx, larynx and esophagus, 50% of cancer of the bladder and 45% of cancer of the pancreas. This small group of cancers represents such a large proportion of all cancer and the death rate among patients with cancers of the lung and pancreas is so high that, in aggregate, the cancer deaths from that portion attributable to smoking is 30% of all deaths from cancer.

Over the next five years, a reduction in smoking to less than 20% of adults and less than 6% of teenagers would reduce the death rate from cancer by 15% by 2000 AD. This would amount to more than 70,000 people saved annually.

* Dr. Huguley is an internist and American Cancer Society Professor of Clinical Oncology, Emory University School of Medicine. Send reprint requests to him at 1365 Clifton Rd., NE, Atlanta, GA 30322.

Prepared at the request of the Georgia Division, American Cancer Society. Others wishing to contribute papers to this Page are invited to send them to T. Gray Fountain, MD, Cancer Page Editor, 910 N. Jefferson, Albany, GA 31708.

Diet

Diet is the next major area of attack. Epidemiologic studies rather clearly implicate dietary fat, especially beef and other animal fat, with cancers of the large bowel and breast. There is a less firm basis for the inverse association of dietary fiber intake with cancer of the large bowel. Both relationships are striking in animal studies. Overfed animals have more cancer of all types. Using the available epidemiologic data and again comparing the incidence of various cancers in Connecticut with that in the areas of lowest incidence, Doll and Peto estimate that the incidences of cancers of the stomach and large bowel can be reduced by 90%, those of cancers of the endometrium, gall bladder, pancreas and breast by 50%, those of cancers of the larynx, bladder, cervix, mouth, pharynx and esophagus by 20%, and of most other cancers by 10% by the application of practical dietary changes. They estimate that this could reduce the death rate of all cancer by 35%. Thus, a 5% reduction in 15 years appears to be attainable.

The dietary changes recommended to achieve this goal are reasonable and similar to the recommendations for avoiding heart disease. They include a reduction in calories, if necessary, to achieve and maintain an optimal weight. Foods should be low in fat with an accent on fruit, vegetables, whole grain breads and cereals, low-fat dairy products, lean meat, poultry (cooked after removal of skin), fish. Fried, smoked, and pickled foods must be avoided. Butter, margarine, oils, and salad dressings must be used sparingly. Such a diet will have an increased fiber content but the addition of bran may help. Foods high in vitamin A or carotene and in vitamin C are recommended as well as the cruciferous vegetables: cabbage, brussel sprouts, and broccoli which have an anti-carcinogen effect.

Alcohol

Alcohol is not an ''initiator'' of cancer but a strong ''promoter'' especially of cancers related to tobacco. Excessive drinking should be avoided.

Estrogens

Estrogens should be prescribed in the lowest effective dose, in combination with progesterone and on an interrupted schedule.

Radiation and Sun Protection

Radiation exposure should be kept to a minimum. Appropriate clothing should be worn for protection from the sun together with an effective sunscreen lotion.

Secondary Prevention — Early Diagnosis

The second aspect of reducing deaths from cancer is ''secondary prevention'' or detection and early diagnosis.[2] There has been a considerable educational effort directed at familiarizing the general public with the symptoms of cancer, and for the most part cancers are being diagnosed earlier than in the past. Nevertheless, when cancer is symptomatic it is already very advanced biologically. Earlier detection by screening before symptoms develop is essential.

Cancer of the cervix

The great success story is the Papanicolaou stain screening for cancer of the uterine cervix. We have reached the majority of women with at least one screen and as a result have greatly reduced the incidence of and mortality from invasive cancer. Nationally, about 74% of cases of cervical cancer are *in situ*. In metropolitan Atlanta, however, 80% are *in situ*. If increasing effort could bring the screening program to a point even better than in Atlanta, we might achieve 90% diagnosis while still *in situ*. This would reduce the national death rate from 6,800 to 2,600, a savings of 4,200 lives, about 1% of all deaths from cancer.

Cancer of the colon and rectum

The second most common cancer is of the colon and rectum, with 130,000 cases a year and 59,400 deaths. The 5-year survival of cases detected early is 77%, compared to 29% if advanced. Currently, only 52% are diagnosed early. The American Cancer Society is launching this year a 3-year program to educate the public and physicians about screening for colo-rectal cancers. Ninety-three percent of such cancers occur after age 50. The recommendation is that all adults past 40 have a digital rectal examination once a year and all past 50 have a rectal exam and a stool blood test annually with a proctoscopic examination every year for 2 years and then every 3-5 years. If an additional 25% of the population past 50 would adopt this regimen, we could increase the percentage of early cases to 65% and reduce deaths from 59,400 to 51,700, a savings of 7,700 lives a year or nearly 2% of the total cancer deaths.

Breast cancer

Breast cancer attacks 115,000 women a year and kills 37,300. The overall 5-year survival is 68%. Early cases have an 88% survival and advanced only 50%. Presently, 47% are early at diagnosis. In the National Breast Cancer Detection Demonstration Project, 80% of the cancers detected had negative axillary nodes. One would predict a 5-year survival of more than 80% for all breast cancer diagnosed among the women in the program. Regular breast self-examination also substantially increases the percentage of cancer that is early at diagnosis. Increasing use of these approaches ought to improve 5-year survival of patients with breast cancer from the present 68% to 75%, saving 8,000 lives or nearly 2% of deaths from cancer.

Screening

Screening for just these three diseases could reasonably be expected to reduce overall cancer mortality by about 5%. Current studies of screening for lung cancer by chest films and sputum cytology are encouraging. Testicle self-examination by young men could make a substantial impact on this potentially curable cancer which is the most common cancer in men less than 35. Together with increasing awareness of the symptoms of all cancers, these screening measures should increase early diagnosis enough to achieve an overall reduction of cancer mortality by more than 6%.

Tertiary Prevention

"Tertiary prevention" is the term applied to reduction in the death rate by general use of the best available treatment. In the past few years, there has been an enormous improvement in the cure rate for all childhood cancer and for leukemias, lymphoma, and osteosarcoma at any age, as well as cancers of the testicle and ovary. Survival of cancer of the breast has been improved by better techniques and appropriate adjuvant therapy. In community and regional cancer centers, the cure rate from cancer overall is considerably better than the national average of 48%. There has always been a lag of a few years in the extension of improved skills throughout the country. An increase in cure rates by improved treatment to 60% would reduce mortality by perhaps 25%.

Summary

Thus we can expect that by a strong program to implement present knowledge and technology, we could have the reasonable potential of reducing cancer deaths by 50% within the next 16 years.

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Ambulatory Blood Pressure Monitoring

L. MICHAEL PRISANT, M.D., ROSE C. TRINCHER, M.D., and ALBERT A. CARR, M.D., *Augusta**

THE ABILITY TO MONITOR ambulatory blood pressure continuously in both normal and hypertensive patients has far-reaching implications. As early as 1940, it was observed that casual office blood pressure measurements might not reflect blood pressure at rest or during daily activities.[1] This observation has always plagued those of us who are asked to evaluate and treat patients with elevated blood pressure discovered on a routine office visit. We truly do not know what happens once the hypertensive leaves the office, but frequently make a decision to prescribe antihypertensive drugs which is seldom again questioned as long as the blood pressure remains "normal" during follow-up casual measurements. It would be extremely beneficial to monitor blood pressure continuously or frequently during usual daily activities. Until recently, this was not possible by a simple, non-invasive, fully automated technique. The development of a valid,[2] reliable[3] R-wave gated piezoelectric pressure transducer (Pressurometer III, Del Mar Avionics, Irvine, CA) has made frequent intermittent ambulatory blood pressure monitoring a reality.

Devices for Monitoring Ambulatory Blood Pressure

Over the years, several devices have been used to monitor ambulatory blood pressure. These devices have given us considerable insight into some difficult problems. The Oxford recorder is an invasive intra-arterial ambulatory blood pressure monitoring system which requires sophisticated equipment to analyze the waveforms obtained. The necessity for intra-arterial invasion precludes its widespread use. The Remler recorder requires manual inflation of the cuff bladder so that readings can be obtained only during the waking hours; this makes it subject to user bias. However, the Remler recorder enabled Sokolow et al.[4] to demonstrate that ambulatory blood pressure measurements provided better correlation with target organ damage than did casual office blood pressure. Perloff et al.[5] examined the incidence of cardiovascular events and death in 1076 patients who underwent ambulatory blood pressure monitoring and were subsequently followed for an average of 5 years. They derived a regression equation which related mean ambulatory blood pressure to the average of three previous office visit blood pressures. In 22% of the patients, the observed ambulatory diastolic blood pressure equalled or exceeded by 6 mm Hg the ambulatory blood pressure predicted by the regression equation. In this group of patients, there were twice as many cardiovascular events (unstable angina, acute myocardial infarction, myocardial ischemia, cerebral ischemia, strokes, and cardiovascular death) as in the rest of the

* With the Section of Hypertension, Medical College of Georgia, Augusta, GA 30912. Send reprint requests to Dr. Prisant.

Articles for this Page are sponsored and approved by the American Heart Association, Georgia Affiliate. Those wishing to contribute papers are invited to send them to Dr. Laurence O. Watkins, "Heart Page" Editor, Section of Cardiology, Dept. of Medicine, MCG, Augusta, GA 30909.

patient group. The deviation of the observed from the predicted ambulatory blood pressure had a prognostic significance independent of age, sex, severity of hypertension, or prior cardiovascular events. These authors have suggested that young subjects with ambulatory diastolic blood pressures greater than 95 mm Hg and no evidence of target organ damage are at increased risk for cardiovascular events and require more intensive therapy.

New Insights Into Hypertension

Though current practice in the diagnosis and treatment of hypertension is guided by simple or repeated blood pressure measurements made in the office (or hospital) settings, the information provided by ambulatory blood pressure monitoring may cast new light on the significance of office blood pressure measurements. Studies have shown that for established and borderline hypertensives, blood pressures measured in the office are higher than those measured at home.[6, 7] The observation that the risk of target organ damage is directly related to the blood pressure level was based on casual office blood pressure measurements.[8, 9] Ambulatory blood pressure monitoring now provides a tool for more precise quantitative assessment of the impact of the pressure load on the heart and the vascular tree.

Automated ambulatory blood pressure monitors are already providing new insights into hypertension. Messerli[10] demonstrated that blood pressure and heart rate gradually declines prior to the onset of sleep and progressively rises prior to waking hours. The diurnal blood pressure variation was not related to urinary catecholamine excretion. In patients designated as "hypertensive," "borderline hypertensive," and "normotensive" by virtue of repeated office blood pressure measurements, similar patterns of blood pressure variability were observed, but there was no overlap in mean ambulatory arterial pressure among the three groups. Ambulatory blood pressure monitoring has also revealed that borderline hypertensive patients have blood pressures that are no more "labile" or variable than the blood pressures of hypertensive or normotensive patients.[11] Devereux, using the Pressurometer II, examined the relationship between echocardiographic evidence of target organ damage (left ventricular hypertrophy) and blood pressure measured by sphygmomanometer in the office and by automatic monitoring at home, work, and sleep. Office blood pressure, automatic home and sleep blood pressures, and total 24 hour blood pressures weakly correlated with left ventricular mass index while automatic systolic and diastolic blood pressure at work were substantially correlated with left ventricular mass index ($r = .50$ and .39, respectively). This suggests a significant relationship between recurring blood pressure response to occupational stress and the development of target organ damage.[12]

Technical Difficulties

Despite a high correlation of ambulatory blood pressure measurements with both intra-arterial or sphygmomanometric measurements, several technical difficulties have been reported. Sheps and co-workers[13] have observed that when a trained technician listened for Korotkoff sounds and used a standard mercury manometer at the same time that these sounds were detected and recorded by the transducer, the transducer measurements deviated from those of the technician by more than 10 mm Hg in 11% of systolic readings and 5% of diastolic readings. The transducer may yield inaccurate recordings of blood pressures in obese patients or in patients who have either a weak pulse or an auscultatory gap.[2] Movement of the transducer in patients with loose skin (elderly patients), excessive arm movement, or muscle tension may result in erroneous measurements.[3] Some of our patients have complained that the device is too heavy (2.0 kg) or that it interferes with sleep.

Application

Use of ambulatory blood pressure monitoring has been suggested for the clinical evaluation of borderline hypertension.[14] Ambulatory blood pressure monitoring would allow more accurate appraisal of the magnitude and severity of blood

pressure elevation and would allow physicians to decide whether treatment is indicated. Also, monitoring could be used to determine the onset, magnitude, and duration of effect of antihypertensive drugs. Such information could guide therapy and allow physicians to monitor and improve compliance.[15, 16] Ambulatory monitoring may also be useful in the evaluation of patients with mitral valve prolapse associated with a hyper-beta-adrenergic state or a hypertensive state associated with endogenous catecholamine release. It may also be of use in evaluating patients at risk of hypotension, for example, patients with congestive heart failure being treated with vasodilators, or patients who have syncopal episodes associated either with primary orthostatic hypotension or arrhythmias.

Summary

Technical improvements in ambulatory blood pressure monitoring devices will allow for more precise evaluation of antihypertensive agents and provide a well-defined method for evaluating drug dosage. The use of such ambulatory blood pressure monitoring may change the evaluation and management of hypertension; furthermore, it may well allow us to predict and prevent target organ damage with greater reliability. More prospective data are needed to relate the development or regression of target organ damage, especially left ventricular hypertrophy, to various aspects of ambulatory blood pressure measurements: 24-hour average, circadian rhythm, variability, and the relationship to stress, home, work, and sleep.

Acknowledgements

The authors would like to express their gratitude to Ms. Mildred Hopewell and Ms. Peggy Best in the preparation of this manuscript.

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ASPIRIN: Allergic or idiosyncratic reactions to aspirin or related compounds.

MEPROBAMATE: Acute intermittent porphyria; allergic or idiosyncratic reactions to meprobamate or related compounds, e.g. carisoprodol, mebutamate, or carbromal.

WARNINGS:
ASPIRIN: Use salicylates with extreme caution in patients with peptic ulcer, asthma, coagulation abnormalities, hypoprothrombinemia, vitamin K deficiency, or those on anticoagulants. In rare instances, aspirin in persons allergic to salicylates may result in life-threatening allergic episodes.

MEPROBAMATE: DRUG DEPENDENCE: Physical and psychological dependence, and abuse have occurred. Chronic intoxication from prolonged ingestion of, usually, greater than recommended doses is manifested by ataxia, slurred speech, and vertigo. Therefore, carefully supervise dose and amounts prescribed and avoid prolonged use, especially in alcoholics and others with known propensity for taking excessive quantities of drugs. Sudden withdrawal after prolonged and excessive use may precipitate recurrence of preexisting symptoms, e.g. anxiety, anorexia, or insomnia, or withdrawal reactions, e.g., vomiting, ataxia, tremors, muscle twitching, confusional states, hallucinosis, and, rarely, convulsive seizures. Such seizures are more likely in persons with CNS damage or preexistent or latent convulsive disorders. Onset of withdrawal symptoms occurs usually within 12 to 48 hours after discontinuation; symptoms usually cease within next 12- to 48-hour period. When excessive dosage has continued for weeks or months, reduce dosage gradually over 1 to 2 weeks rather than stop abruptly. Alternatively, a short-acting barbiturate may be substituted, then gradually withdrawn.

POTENTIALLY HAZARDOUS TASKS: Warn patients meprobamate may impair mental or physical abilities required for potentially hazardous tasks, e.g., driving or operating machinery.

ADDITIVE EFFECTS: Since CNS-suppressant effects of meprobamate and alcohol or meprobamate and other psychotropic drugs may be additive, exercise caution with patients taking more than one of these agents simultaneously.

USAGE IN PREGNANCY AND LACTATION:
An increased risk of congenital malformations associated with minor tranquilizers (meprobamate, chlordiazepoxide, and diazepam) during first trimester of pregnancy, has been suggested in several studies. Because use of these drugs is rarely a matter of urgency, their use during this period should almost always be avoided. The possibility that a woman of childbearing potential may be pregnant at time of institution of therapy should be considered. Advise patients if they become pregnant during therapy or intend to become pregnant to communicate with their physicians about desirability of discontinuing the drug.

Meprobamate passes the placental barrier. It is present both in umbilical-cord blood at or near maternal plasma levels and in breast milk of lactating mothers at concentrations two to four times that of maternal plasma. When use of meprobamate is contemplated in breastfeeding patients, consider the drug's higher concentrations in breast milk as compared to maternal plasma levels.

USAGE IN CHILDREN: Keep preparations with aspirin out of reach of children. Equagesic® (meprobamate with aspirin) is not recommended for patients 12 years of age and under.

PRECAUTIONS:
ASPIRIN: Salicylates antagonize uricosuric activity of probenecid and sulfinpyrazone. Salicylates are reported to enhance hypoglycemic effect of sulfonylurea antidiabetics.

MEPROBAMATE: Use lowest effective dose, particularly in elderly and/or debilitated, to preclude over-sedation. Meprobamate is metabolized in the liver and excreted by the kidney, to avoid excess accumulation exercise caution in its use in patients with compromised liver or kidney function. Meprobamate occasionally may precipitate seizures in epileptic patients. It should be prescribed cautiously and in small quantities to patients with suicidal tendencies.

ADVERSE REACTIONS:
ASPIRIN: May cause epigastric discomfort, nausea, and vomiting. Hypersensitivity reactions, including urticaria, angioneurotic edema, purpura, asthma, and anaphylaxis may rarely occur. Patients receiving large doses of salicylates may develop tinnitus.

MEPROBAMATE: CNS: Drowsiness, ataxia, dizziness, slurred speech, headache, vertigo, weakness, paresthesias, impairment of visual accommodation, euphoria, overstimulation, paradoxical excitement, fast EEG activity.

GI: Nausea, vomiting, diarrhea.

CARDIOVASCULAR: Palpitation, tachycardia, various forms of arrhythmia, transient ECG changes, syncope, hypotensive crisis.

ALLERGIC OR IDIOSYNCRATIC: Milder reactions are characterized by itchy, urticarial, or erythematous maculopapular rash, generalized or confined to the groin. Other reactions include leukopenia, acute nonthrombocytopenic purpura, petechiae, ecchymoses, eosinophilia, peripheral edema, adenopathy, fever, fixed drug eruption with cross-reaction to carisoprodol, and cross-sensitivity between meprobamate/mebutamate and meprobamate/carbromal. Rare, more severe hypersensitivity reactions include hyperpyrexia, chills, angioneurotic edema, bronchospasm, oliguna, and anuria. Also, anaphylaxis, exfoliative dermatitis, stomatitis, and proctitis. Stevens-Johnson syndrome and bullous dermatitis have occurred.

HEMATOLOGIC (SEE ALSO "ALLERGIC OR IDIOSYNCRATIC"): Agranulocytosis, aplastic anemia have been reported, although no causal relationship has been established, and thrombocytopenic purpura.

OTHER: Exacerbation of porphyric symptoms.

DOSAGE AND ADMINISTRATION:
Usual dose is one or two tablets, 3 to 4 times daily as needed for relief of pain when tension or anxiety is present. Not recommended for patients 12 years of age and under.

OVERDOSAGE:
Treatment is essentially symptomatic and supportive. Any drug remaining in the stomach should be removed. Induction of vomiting or gastric lavage may be indicated. Activated charcoal may reduce absorption of both aspirin and meprobamate. Aspirin overdosage produces usuel symptoms and signs of salicylate intoxication. Observation and treatment should include management of hyperthermia, specific parenteral electrolyte therapy for ketoacidosis and dehydration, watching for evidence of hemorrhagic manifestations due to hypoprothrombinemia which, if it occurs, usually requires whole-blood transfusions. Suicidal attempts with meprobamate have resulted in drowsiness, lethargy, stupor, ataxia, coma, shock, vasomotor and respiratory collapse. Some suicidal attempts have been fatal. The following data, reported in the literature and from other sources, are not expected to correlate with each case (considering factors such as individual susceptibility and length of time from ingestion to treatment), but represent usual ranges reported. Acute simple overdose (meprobamate alone): Death has been reported with ingestion of as little as 12 grams meprobamate and survival with as much as 40 grams.

BLOOD LEVELS:
0.5-2.0 mg percent represents usual blood-level range of meprobamate after therapeutic doses. The level may occasionally be as high as 3.0 mg percent.

3-10 mg percent usually corresponds to findings of mild-to-moderate symptoms of overdosage, such as stupor or light coma.

10-20 mg percent usually corresponds to deeper coma, requiring more intensive treatment. Some fatalities occur.

At levels greater than 20 mg percent, more fatalities than survivals can be expected.

Acute combined overdose (meprobamate with other psychotropic drugs or alcohol): Since effects can be additive, history of ingestion of a low dose of meprobamate plus any of these compounds (or of a relatively low blood or tissue level) cannot be used as a prognostic indicator.

In cases of excessive doses, sleep ensues rapidly and blood pressure, pulse, and respiratory rates are reduced to basal levels. Any drug remaining in stomach should be removed and symptomatic treatment given. Should respiration or blood pressure become compromised, respiratory assistance, CNS stimulants, and pressor agents should be administered cautiously as indicated. Diuresis, osmotic (mannitol) diuresis, peritoneal dialysis, and hemodialysis have been used successfully in removing both aspirin and meprobamate. Alkalinization of the urine increases excretion of salicylates. Careful monitoring of urinary output is necessary, and caution should be taken to avoid overhydration. Relapse and death, after initial recovery, have been attributed to incomplete gastric emptying and delayed absorption.

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The Physician's Statutory Obligation to Furnish Medical Records to Patients

ROBERT N. BERG, *Atlanta**

UNTIL RECENTLY, the physician in Georgia who received a request from a patient to allow the patient (or his or her authorized representative) to have access to the physician's medical records concerning the patient was not legally obligated to comply with that request. As a practical matter, most physicians routinely did comply with these patient requests; moreover, the American Medical Association has suggested that "on request of the patient a physician should provide a copy or a summary of the record to the patient or to another physician, an attorney, or other person designated by the patient."[1]

Nevertheless, physicians sometimes took the position that the patient had no absolute right to inspect the medical records pertaining to his or her medical treatment, in the absence of a substantial reason. The rationale most often cited for this position was that, in most cases, the patient lacked the background and knowledge to read and understand the medical records properly.[2]

As a result of a new statute enacted by the Georgia General Assembly during the 1984 legislative session,[3] physicians in Georgia appear no longer to have any significant discretion in terms of responding to patient requests for access to their medical records. Rather, Georgia physicians are now *obligated* to provide access to their medical records, to patients (or their authorized representatives), upon request.

The basic thrust of O.C.G.A. Chapter 31-32 (the "Statute")[4] is that, upon written request from a patient, certain institutional and individual providers having custody and control of the patient's record are required to furnish a complete and current copy of that record to the patient or a person authorized by the patient.[5] This month's Legal Page takes a closer look at the physician's obligations under the Statute.

Which "Providers" Are Subject to the Disclosure Obligations Under the Statute?

As defined in the Statute, the term "provider" encompasses most of the persons and entities involved in the delivery of health care services. Specifically, a "provider" is defined as including "all hospitals, including public, private, osteopathic, and tuberculosis hospitals; other special care units, including podiatric facilities, skilled nursing facilities, and kidney disease treatment centers, including free standing hemodialysis units; intermediate care facilities; ambulatory surgical or obstetrical facilities; health maintenance organizations; and home health agencies." The term "provider" also includes all persons licensed to practice by the

* Prepared at the request of the Medical Association of Georgia. Mr. Berg is a partner in the firm of Powell, Goldstein, Frazer & Murphy, General Counsel to the Association, 1100 C & S National Bank Building, Atlanta, GA 30335.

Georgia Board of Chiropractic Examiners, the Georgia Board of Dentistry, the Georgia Board of Nursing, the Composite State Board of Medical Examiners, the State Board of Podiatry Examiners, or the State Board of Examiners of Psychologists.[6] (The inclusion of psychologists in the definition of "provider" is a bit misleading, however, since the Statute specifically is inapplicable with regard to "psychiatric, psychological or other mental health records of a patient."[7])

Who Is a "Patient" For Purposes of the Statute?

The Statute defines a patient as "any person who has received health care services from a provider."[8] Thus, both current *and former* patients are entitled to have access to their medical records.

What "Medical Records" Must Be Provided to the Patient?

The Statute defines the term "record" for use in determining exactly what the provider is obligated to disclose to the patient upon request; the term "record" means "a patient's health record, including, but not limited to, evaluations, diagnoses, prognoses, laboratory reports, x-rays, prescriptions, and other technical information used in assessing the patient's condition, or the pertinent portion of the record relating to a specific condition or a summary of the record."[9]

Who Can the Patient Designate as an Authorized Representative to Review His or Her Records?

Essentially, the patient can designate any person to obtain access to the patient's medical records. The Statute requires the provider to furnish a complete and current copy of the medical record not only to the patient but also to any other provider or any other person designated by the patient.[10]

What If the Provider Believes That Disclosure of a Patient's Medical Record to the Patient May Jeopardize the Patient's Health or Well-being?

The Statute deals with this situation by authorizing the provider, upon a reasonable determination that the disclosure of the records to the patient will be detrimental to the physical or mental health of the patient, to refuse to furnish the record. In that situation, however, the provider must furnish the patient's medical record, upon written request by the patient, to any other provider designated by the patient.[11]

Can the Provider Charge the Patient for the Expenses of Copying and Mailing the Medical Record?

Under the Statute, the party requesting the patient's records is responsible to the provider for the reasonable cost of copying and mailing the patient's records. Payment of such costs may be required by the provider prior to the records being furnished, except in situations where the records requested are necessary in order to make or complete an application for a disability benefits program.[12]

Can the Provider Be Held Liable for Disclosing the Patient's Medical Record?

The Statute specifically states that any provider releasing information in good faith pursuant to the provisions of the Statute shall not be civilly or criminally liable to the patient, guardian, parent, or any other person for such release.[13] Thus, only if the physician acted in bad faith in disclosing the medical records — e.g., if the physician disclosed the records to an unauthorized person, or made disclosure on the basis of an authorization which the physician knew was forged — could the physician incur civil or criminal liability with regard to the disclosure.

Who "Owns" the Medical Records, the Provider or the Patient?

In a number of cases, courts in other states have held that medical records are the personal property of the provider, not the patient, reasoning that the patient

purchases the provider's services (e.g., the *interpretation* of an x-ray), rather than the medical records used by the provider in reaching a medical judgment (e.g., the x-ray itself).[14] No court in Georgia, however, has rendered a decision on this issue, thus leaving open at least a possibility that patients in Georgia might have some ownership interest in the medical records concerning their treatment.

With the enactment of the Statute, the question of ownership of medical records is no longer an open one in Georgia. Under the Statute, all medical records "are owned by and are the property of the provider."[15]

Notes

1. Current Opinions of the Judicial Council of the American Medical Association (1984), at §7.01.
2. See, *e.g., Lawyers' Medical Cyclopedia,* Vol. 1, §3.21, at p. 245.
3. Ga. L. 1984, p. 1680, §1 (effective April 6, 1984).
4. For unexplained reasons, the Georgia General Assembly enacted *two* new Chapters 32 to Title 31, one dealing with living wills and the other dealing with medical records. The Michie Company, publisher of the O.C.G.A., has unofficially designated the living will statute as O.C.G.A. Chapter 31-32 and redesignated the medical records statute as O.C.G.A. Chapter 31-32[33].
5. O.C.G.A. §31-32-2(a) [§31-33-2(a)].
6. O.C.G.A. §31-32-1(2) [§31-33-1(2)].
7. O.C.G.A. §31-32-4 [§31-33-4].
8. O.C.G.A. §31-32-1(1) [§31-33-1(1)].
9. O.C.G.A. §31-32-1(3) [§31-33-1(3)].
10. O.C.G.A. §31-32-2(b) [§31-33-2(b)].
11. O.C.G.A. §31-32-2(c) [§31-33-2(c)].
12. O.C.G.A. §31-32-3(a) [§31-33-3(a)].
13. O.C.G.A. §31-32-5 [§31-33-5].
14. See, *e.g., Gotkin v. Miller,* 379 F. Supp. 859 (E.D.N.Y. 1974); Current Opinions of the Judicial Council of the American Medical Association (1984), at §7.02.
15. O.C.G.A. §31-32-3(b) [§31-33-3(b)].

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president's letter



Am I My Brother's Keeper?

The Impaired Physicians Program in Georgia, under the capable leadership of G. Douglas Talbott, M.D., is now recognized as one of the most outstanding programs of its kind in the United States.

In 1972, the AMA House of Delegates adopted as policy a report of the Council of Mental Health entitled, "The Sick Physician." The key sentence of this report was, "It is a physician's ethical responsibility to take cognizance of a colleague's inability to practice medicine adequately by reason of physical or mental illness including alcoholism or drug dependence."

The Georgia Impaired Physicians Program, then called "The Disabled Doctors Plan," was begun in 1974 when Dr. Talbott moved from Baltimore to DeKalb County to begin work. His early support was from the DeKalb County Medical Society. Financial support was requested and received from the MAG beginning in 1975. Since that time, the MAG has given financial and other support to this worthwhile program as it has grown to one of national stature. The Physicians Consultants Committee and the Impaired Physicians Committee are active components of the MAG committee structure.

MAG support of this endeavor is another good answer to the often heard question, "What does the MAG do for me?" What better way could we spend some of your dues dollars than toward helping a fellow physician who is at the "end of his road" in chemical addiction? What better return on an investment could we ask than to see one of our members rehabilitated and returned to productive medical practice?

What causes a person to become chemically dependent? Why do some social drinkers and occasional drug users get hooked while others do not? "Physicians, of all people, should know better," you might say. Yet we must all realize that as human beings, physicians are subject to the same weaknesses and disorders as others. Moreover, the stress of practice and the availability of drugs makes it easier for a physician to become involved, particularly in drug addiction.

Articles concerning the Impaired Physicians Program in Georgia are highlighted in this special issue of the *Journal*. Read them and be proud of the part your MAG plays in this Program. Yes, we really are "our brother's keeper"!

S. William Clark

S. William Clark, Jr., M.D.

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105 Collier Rd., NW, Ste. 4060, Atlanta 30367

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Braunstein, Kenneth M., MAA — ACT — IM/HEM
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Burnett, Clifford F., III, MAA — ACT — IM
370 Junction Track, Roswell 30075

Burnett, Jettie M., MAA — Associate — OPH
5530 Old National Hwy., College Park 30349

Craig, Donna M., MAA — ACT (N-2) — IM/NEP
3250 Howell Mill Rd., NW, Atlanta 30327

deGive, Elizabeth D., Newton-Rockdale — ACT (N-2) — IM
1309 Milstead Rd., Conyers 30207

deGive, James R., Newton-Rockdale — ACT (N-2) — IM
1309 Milstead Rd., Conyers 30207

Demosthenes, Charles S., MAA — ACT — IM
3810 Pleasantdale Rd., Atlanta 30340

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3475 Lenox Rd., NE, #480, Atlanta 30326

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510 Washington Ave., Sandersville 31082

Correction:
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810 Thirteenth Ave., Albany 31705

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490 Peachtree St., NE, Ste. 372-C, Atlanta 30308

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1365 Clifton Rd., NE, Atlanta 30322

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960 Johnson Ferry Rd., NE, Ste. 520, Atlanta 30342

PERSONALS

First District

Eloise B. Sherman, M.D., has opened an office for the private practice of general medicine in Savannah. Dr. Sherman has been in the practice of pathology since 1971 and is a fellow in the College of American Pathologists and the American Society of Clinical Pathologists. She is a former First Vice President of the MAG.

Second District

Walter Carl Gordon, Jr., M.D., a general surgeon from Albany, was presented the Percy L. Julian Memorial Award in Chicago for his outstanding and unselfish achievements in the art of medicine. The award paid tribute to his founding and promotion of the Faith Fund Foundation.

Patricia Lee June, M.D., has opened a practice in pediatrics in Moultrie.

Fourth District

Atlanta physician, **Athanosios Verras, M.D.,** was elected to fellowship in the American Academy of Pediatrics at a recent meeting of the AAP Executive Board.

Fifth District

Steven D. Feinberg, M.D., has joined the staff of the North Fulton Medical Center as medical director of the new rehabilitation unit, which opened October 8.

Richard A. Levitt, M.D., of Roswell, was elected to fellowship in the American Academy of Pediatrics. He is vice chairman of pediatrics at Scottish Rite Hospital for Crippled Children.

Georgia Baptist Medical Center has announced the opening of a recently completed Trauma Unit located adjacent to the Emergency Department. The Director of Trauma Service, GBMC, is **John P. Wilson, M.D., F.A.C.S.,** and the Director of Emergency Services is **Rodger Chapman, M.D.**

Eighth District

Valdosta general surgeon, **Jerry Gaines Purvis, M.D.,** has been named a Board member of the Medical College of Georgia Foundation.

Ninth District

Theodore R. Robinson, M.D., of Gainesville, took office as President of the Georgia Occupational Medical Association at the annual business meeting in Atlanta on September 7. Dr. Robinson is Medical Director for Chicopee and for Johnson & Johnson's Southeastern Region. He also is a member of the Board of Directors of the American Occupational Medical Association.

Tenth District

Elizabeth D. deGive, M.D., James R. deGive, M.D., and **David Almand, M.D.,** have opened a practice in Conyers. The new group is named the Conyers Internal Medicine Group.

DEATHS

Herbert Royce Frost

Herbert Royce Frost, M.D., 55, died September 7 at University Hospital, Augusta, after a brief illness. Dr. Frost was a retired family practitioner and surgeon from Swainsboro. He served in the U.S. Army Medical Corps from 1957 to 1959 and was chief of staff of Swainsboro National Guard Medical Unit for a number of years. Dr. Frost was a graduate of Emory University and the Medical College of Georgia. He was a member of the American College of Abdominal Surgeons, the American Academy of Family Practitioners, and was former chief of staff of Emanuel County Hospital.

Survivors include his wife, one son, two daughters, and one brother.

Classifieds . . .

PHYSICIAN WANTED

Research Faculty Position Available in the Division of Nephrology and Inorganic Metabolism, Department of Medicine, Emory University School of Medicine. Position is for a Ph.D. at the Assistant Professor Level. Individual must have post-doctoral training and experience in renal physiology and biochemistry and must have a specific interest in the mechanisms of renal glutamine metabolism and renal ammoniagenesis. Experience with the isolated perfused rat kidney, renal tubular cell cultures, and subcellular fractionation is desirable. The successful candidate will be expected to both conduct independent research and participate in ongoing projects in the area. Interested applicants should send not later than Dec. 15, 1984, curriculum vitae, bibliography, and three letters of reference to Dr. J. Willis Hurst, Chairman, Dept. of Med., Emory Univ. Sch. of Med., 69 Butler St., SE, Atlanta 30303. An Equal Opportunity/Affirmative Action Employer.

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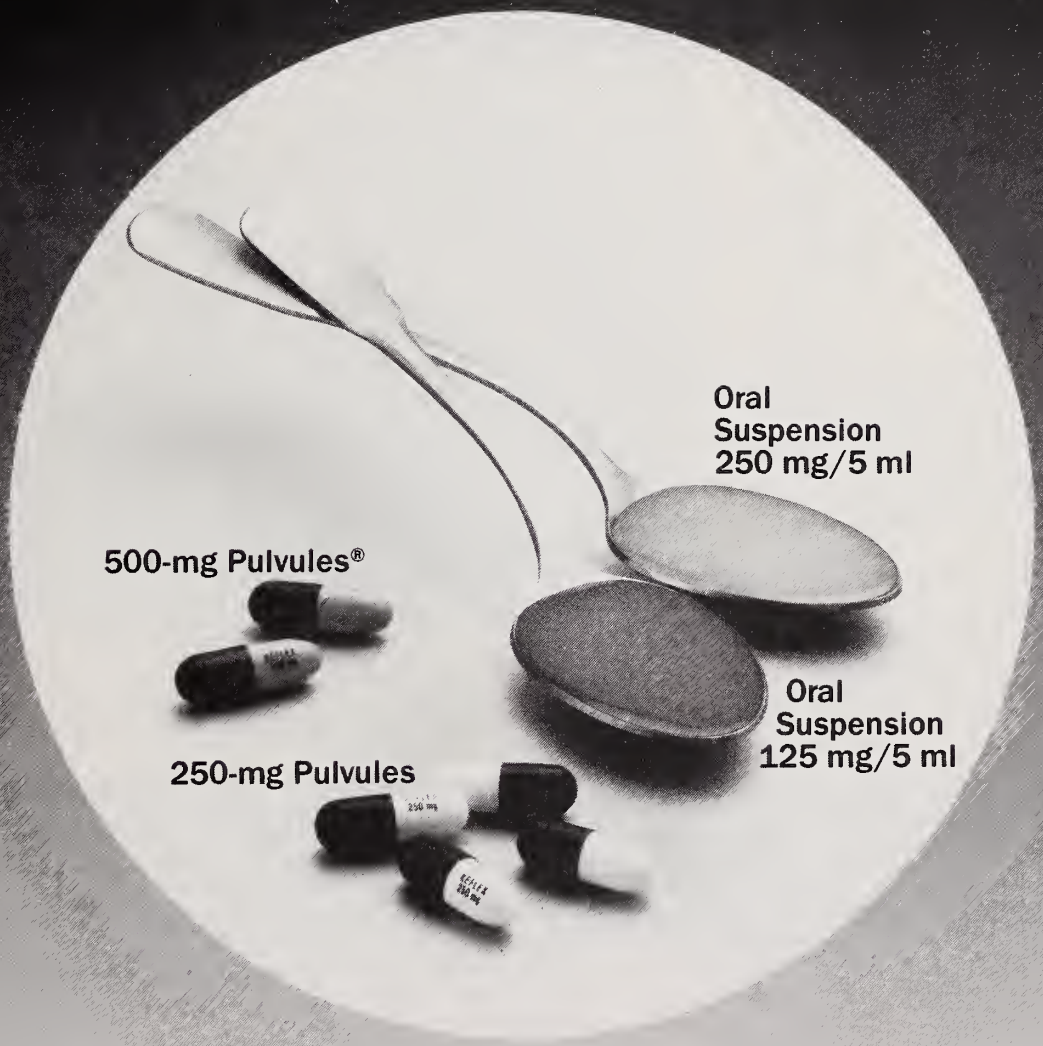
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(Continued on page 794)

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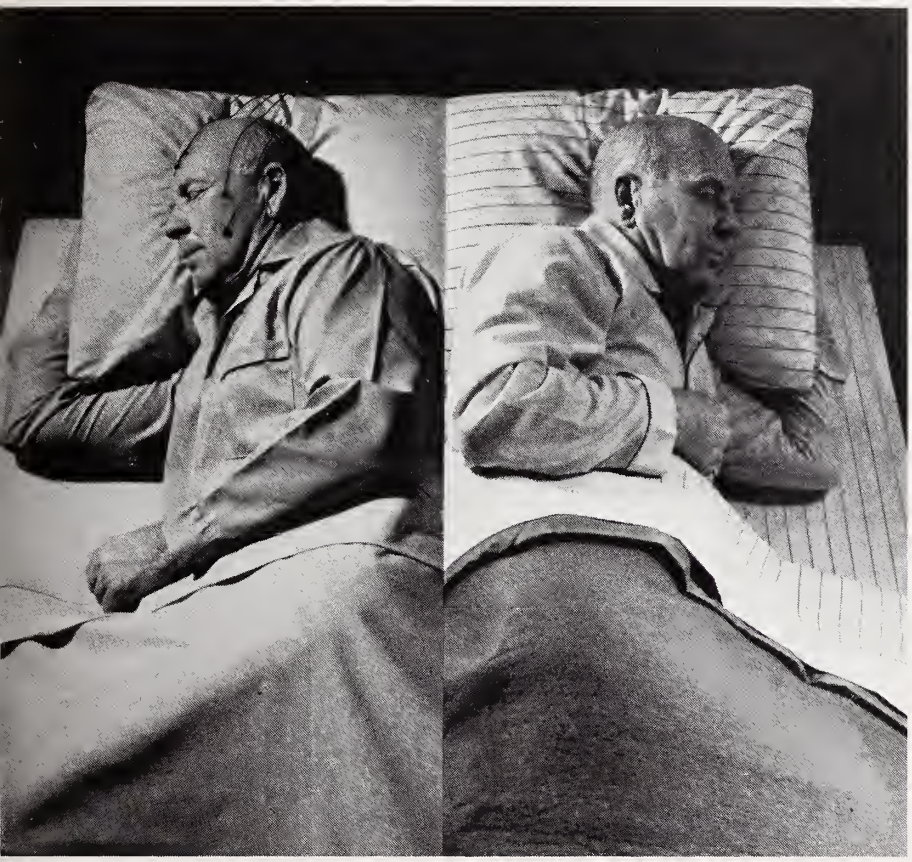
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Caution patients about driving, operating hazardous machinery or drinking alcohol during therapy. Limit dose to 15 mg in elderly or debilitated patients. Contraindicated during pregnancy.

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References: **1.** Kales J *et al*: *Clin Pharmacol Ther* 12:691-697, Jul-Aug 1971. **2.** Kales A *et al*: *Clin Pharmacol Ther* 18:356-363, Sep 1975. **3.** Kales A *et al*: *Clin Pharmacol Ther* 19:576-583, May 1976. **4.** Kales A *et al*: *Clin Pharmacol Ther* 32:781-788, Dec 1982. **5.** Frost JD Jr, DeLucchi MR: *J Am Geriatr Soc* 27:541-546, Dec 1979. **6.** Kales A, Kales JD: *J Clin Pharmacol* 3:140-150, Apr 1983. **7.** Greenblatt DJ, Allen MD, Shader RI: *Clin Pharmacol Ther* 21:355-361, Mar 1977. **8.** Zimmerman AM: *Curr Ther Res* 13:18-22, Jan 1971. **9.** Amrein R *et al*: *Drugs Exp Clin Res* 9(1):85-99, 1983. **10.** Monti JM: *Methods Find Exp Clin Pharmacol* 3:303-326, May 1981. **11.** Greenblatt DJ *et al*: *Sleep* 5(Suppl 1):S18-S27, 1982. **12.** Kales A *et al*: *Pharmacology* 26:121-137, 1983.

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Indications: Effective in all types of insomnia characterized by difficulty in falling asleep, frequent nocturnal awakenings and/or early morning awakening; in patients with recurring insomnia or poor sleeping habits; in acute or chronic medical situations requiring restful sleep. Objective sleep laboratory data have shown effectiveness for at least 28 consecutive nights of administration. Since insomnia is often transient and intermittent, prolonged administration is generally not necessary or recommended. Repeated therapy should only be undertaken with appropriate patient evaluation.

Contraindications: Known hypersensitivity to flurazepam HCl; pregnancy. Benzodiazepines may cause fetal damage when administered during pregnancy. Several studies suggest an increased risk of congenital malformations associated with benzodiazepine use during the first trimester. Warn patients of the potential risks to the fetus should the possibility of becoming pregnant exist while receiving flurazepam. Instruct patient to discontinue drug prior to becoming pregnant. Consider the possibility of pregnancy prior to instituting therapy.

Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants. An additive effect may occur if alcohol is consumed the day following use for nighttime sedation. This potential may exist for several days following discontinuation. Caution against hazardous occupations requiring complete mental alertness (*e.g.*, operating machinery, driving). Potential impairment of performance of such activities may occur the day following ingestion. Not recommended for use in persons under 15 years of age. Though physical and psychological dependence have not been reported on recommended doses, abrupt discontinuation should be avoided with gradual tapering of dosage for those patients on medication for a prolonged period of time. Use caution in administering to addiction-prone individuals or those who might increase dosage.

Precautions: In elderly and debilitated patients, it is recommended that the dosage be limited to 15 mg to reduce risk of oversedation, dizziness, confusion and/or ataxia. Consider potential additive effects with other hypnotics or CNS depressants. Employ usual precautions in severely depressed patients, or in those with latent depression or suicidal tendencies, or in those with impaired renal or hepatic function.

Adverse Reactions: Dizziness, drowsiness, lightheadedness, staggering, ataxia and falling have occurred, particularly in elderly or debilitated patients. Severe sedation, lethargy, disorientation and coma, probably indicative of drug intolerance or overdosage, have been reported. Also reported: headache, heartburn, upset stomach, nausea, vomiting, diarrhea, constipation, GI pain, nervousness, talkativeness, apprehension, irritability, weakness, palpitations, chest pains, body and joint pains and GU complaints. There have also been rare occurrences of leukopenia, granulocytopenia, sweating, flushes, difficulty in focusing, blurred vision, burning eyes, faintness, hypotension, shortness of breath, pruritus, skin rash, dry mouth, bitter taste, excessive salivation, anorexia, euphoria, depression, slurred speech, confusion, restlessness, hallucinations, and elevated SGOT, SGPT, total and direct bilirubins, and alkaline phosphatase; and paradoxical reactions, *e.g.*, excitement, stimulation and hyperactivity.

Dosage: Individualize for maximum beneficial effect. *Adults:* 30 mg usual dosage; 15 mg may suffice in some patients. *Elderly or debilitated patients:* 15 mg recommended initially until response is determined.

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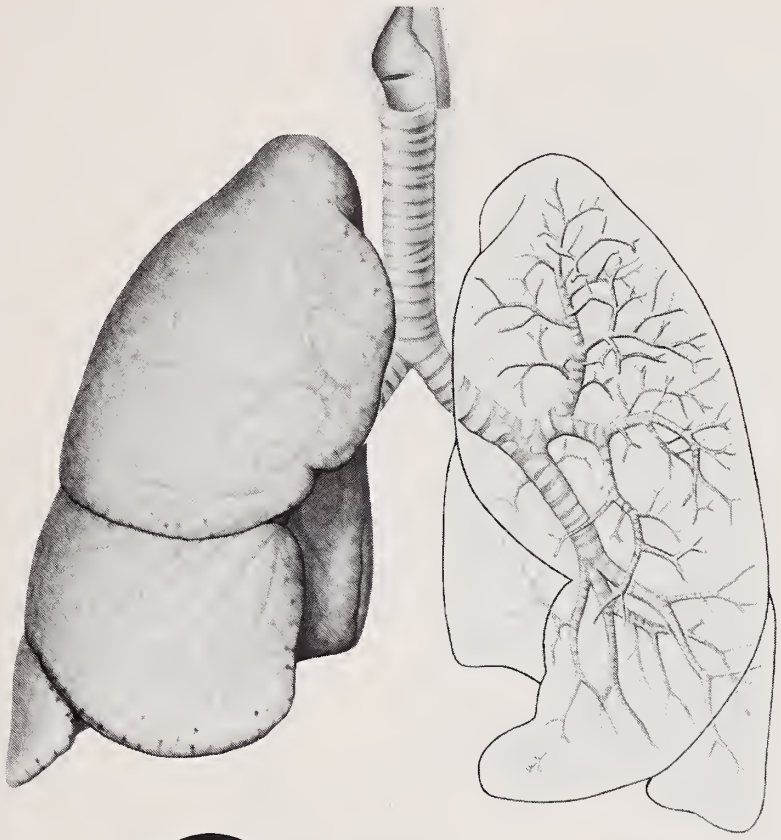
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s, including Ceclor, should be administered cautiously
nt who has demonstrated some form of allergy,
to drugs.
embranous colitis has been reported with virtually all
um antibiotics (including macrolides, semisynthetic
and cephalosporins); therefore, it is important to
diagnosis in patients who develop diarrhea in
with the use of antibiotics. Such colitis may range in
n mild to life-threatening.
with broad-spectrum antibiotics alters the normal
olon and may permit overgrowth of clostridia. Studies
a toxin produced by *Clostridium difficile* is one
e of antibiotic-associated colitis.
s of pseudomembranous colitis usually respond to
nuance alone. In moderate to severe cases, manage-
ment should include sigmoidoscopy, appropriate bacteriologic studies, and fluid, electrolyte, and protein supplementation. When the colitis does not improve after the drug has been discontinued, or when it is severe, oral vancomycin is the drug of choice for antibiotic-associated pseudomembranous colitis produced by *C. difficile*. Other causes of colitis should be ruled out.

Precautions: *General Precautions* — If an allergic reaction to Ceclor* (cefaclor, Lilly) occurs, the drug should be discontinued, and, if necessary, the patient should be treated with appropriate agents, e.g., pressor amines, antihistamines, or corticosteroids.

Prolonged use of Ceclor may result in the overgrowth of nonsusceptible organisms. Careful observation of the patient is essential. If superinfection occurs during therapy, appropriate measures should be taken.

Positive direct Coombs' tests have been reported during treatment with the cephalosporin antibiotics. In hematologic studies or in transfusion cross-matching procedures when antiglobulin tests are performed on the minor side or in Coombs' testing of newborns whose mothers have received cephalosporin antibiotics before parturition, it should be recognized that a positive Coombs' test may be due to the drug.

Ceclor should be administered with caution in the presence of markedly impaired renal function. Under such conditions, careful clinical observation and laboratory studies should be made because safe dosage may be lower than that usually recommended.

As a result of administration of Ceclor, a false-positive reaction for glucose in the urine may occur. This has been observed with Benedict's and Fehling's solutions and also with Clinitest* tablets but not with Tes-Tape* (Glucose Enzymatic Test Strip, USP, Lilly).

Broad-spectrum antibiotics should be prescribed with caution in individuals with a history of gastrointestinal disease, particularly colitis.

Usage in Pregnancy — Pregnancy Category B — Reproduction studies have been performed in mice and rats at doses up to 12 times the human dose and in ferrets given three times the maximum human dose and have revealed no evidence of impaired fertility or harm to the fetus due to Ceclor* (cefaclor, Lilly). There are, however, no adequate and well-controlled studies in pregnant women. Because animal reproduction studies are not always predictive of human response, this drug should be used during pregnancy only if clearly needed.

Nursing Mothers — Small amounts of Ceclor have been detected in mother's milk following administration of single 500-mg doses. Average levels were 0.18, 0.20, 0.21, and 0.16 mcg/ml at two, three, four, and five hours respectively. Trace amounts were detected at one hour. The effect on nursing infants is not known. Caution should be exercised when Ceclor is administered to a nursing woman.

Usage in Children — Safety and effectiveness of this product for use in infants less than one month of age have not been established.

Adverse Reactions: Adverse effects considered related to therapy with Ceclor are uncommon and are listed below:

Gastrointestinal symptoms occur in about 2.5 percent of patients and include diarrhea (1 in 70).

Symptoms of pseudomembranous colitis may appear either during or after antibiotic treatment. Nausea and vomiting have been reported rarely.

Hypersensitivity reactions have been reported in about 1.5 percent of patients and include morbilliform eruptions (1 in 100). Pruritus, urticaria, and positive Coombs' tests each occur in less than 1 in 200 patients. Cases of serum-sickness-like reactions (erythema multiforme or the above skin manifestations accompanied by arthritis/arthralgia and, frequently, fever) have been reported. These reactions are apparently due to hypersensitivity and have usually occurred during or following a second course of therapy with Ceclor. Such reactions have been reported more frequently in children than in adults. Signs and symptoms usually occur a few days after initiation of therapy and subside within a few days after cessation of therapy. No serious sequelae have been reported. Antihistamines and corticosteroids appear to enhance resolution of the syndrome.

Cases of anaphylaxis have been reported, half of which have occurred in patients with a history of penicillin allergy.

Other effects considered related to therapy included eosinophilia (1 in 50 patients) and genital pruritus or vaginitis (less than 1 in 100 patients).

Causal Relationship Uncertain — Transitory abnormalities in clinical laboratory test results have been reported. Although they were of uncertain etiology, they are listed below to serve as alerting information for the physician.

Hepatic — Slight elevations in SGOT, SGPT, or alkaline phosphatase values (1 in 40).

Hematopoietic — Transient fluctuations in leukocyte count, predominantly lymphocytosis occurring in infants and young children (1 in 40).

Renal — Slight elevations in BUN or serum creatinine (less than 1 in 500) or abnormal urinalysis (less than 1 in 200).

[D617B2R]

Note. Ceclor* (cefaclor, Lilly) is contraindicated in patients with known allergy to the cephalosporins and should be given cautiously to penicillin-allergic patients.

Penicillin is the usual drug of choice in the treatment and prevention of streptococcal infections, including the prophylaxis of rheumatic fever. See prescribing information.

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THE COVER

MAG's Third Annual Leadership Conference in February, 1985, will offer specific directions to guide you through the maze of medical practice options available now and in the future.

Cover photo by Chuck Rogers, of Atlanta; cover design by Jeanne Adams, of Atlanta.

MEDICAL MEETING CALENDAR

FEBRUARY

1-2—*Atlanta:* **MAG Leadership Conference.** Contact MAG, 938 Peachtree St., N.E., Atlanta 30309. PH:404/876-7535 or 1-800-282-0224 (toll free in Ga.).

4-8—*Puerto Vallarta, Mexico:* **Ninth Annual Conference on Pain.** Category 1 credit. Contact Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., NE, Ste. 100, Atlanta 30322. PH:404/329-5695.

6-10—*Puerto Vallarta, Mexico:* **Scottish Rite 7th Annual Pediatric Postgraduate Course.** Category 1 credit. Contact Judson L. Hawk, Jr., M.D., Dir. of Ped. Ed., Scottish Rite Children's Hosp., 1001 Johnson Ferry Rd., Atlanta 30363. PH:404/257-2040.

7-10—*Atlanta:* **Georgia Psychiatric Association Winter Meeting.** Category 1 credit. Contact S. Reaves Lee, M.D., 1493 LaVista Road, NE, Atlanta 30324. PH:404/321-5259.

18-22—*Park City, Utah:* **Third Annual Winter Urology Seminar.** Category 1 credit. Contact Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., NE, Ste. 110, Atlanta 30322. PH:404/329-5695.

18-23—*Augusta:* **Family Practice Symposium.** Category 1 credit. Contact Div. of Cont. Ed., MCG, Augusta 30912. PH:404/828-3967.

21-22—*Atlanta:* **Sickle Cell 1984: Problems and Issues.** Category 1 credit. Contact Dir. of Med. Ed., Morehouse School of Medicine, 720 Westview Dr., SW, Atlanta 30314.

MARCH

11-15—*Park City, Utah:* **Orthopaedics Course.** Category 1 credit. Contact Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., NE, Ste. 110, Atlanta 30322. PH:404/329-5695.

11-16—*Augusta:* **20th Annual Family Practice Symposium.** Category 1 credit. Contact Div. of Cont. Ed.. MCG, Augusta 30912. PH:404/828-3967.

13—*Augusta:* **Antepartum Electronic Fetal Heart Rate Monitoring Theory and Practice.** Category 1 credit. Contact Div. of Cont. Ed., MCG, Augusta 30912. PH:404/828-3967.

18-22—*Park City, Utah:* **Orthopaedics Course.** Category 1 credit. Contact Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., NE, Ste. 110, Atlanta 30322. PH:404/329-5695.

22-23—*Atlanta:* **Sports Medicine.** Category 1 credit. Contact Dir. of Med. Ed., Morehouse School of Medicine, 740 Westview Dr., SW, Atlanta 30314.

APRIL

11-13—*Atlanta:* **Introduction Into Percutaneous Transluminal Angioplasty V.** Category 1 credit. Contact Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., NE, Ste. 110, Atlanta 30322. PH:404/329-5695.

14-18—*Atlanta:* **Demonstrations in Percutaneous Transluminal Angioplasty XIII.** Category 1 credit. Contact Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., NE, Ste. 110, Atlanta 30322. PH:404/329-5695.

25-27—*Atlanta:* **Practical Applications of Computers in Health Care: The Integration of Clinical and Administration Information.** Category 1 credit. Contact Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., NE, Ste. 110, Atlanta 30322. PH:404/329-5695.

25-28—*Savannah:* **MAG House of Delegates.** Contact MAG, 938 Peachtree St., NE, Atlanta 30309. PH:404/876-7535 or 1-800-282-0224 (toll free in Ga.).

28-May 1—*Atlanta:* **Magnetic Resonance Imaging.** Category 1 credit. Contact Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., NE, Ste. 110, Atlanta 30322. PH:404/329-5695.

29-May 4—*Augusta:* **20th Annual Family Practice Symposium.** Category 1 credit. Contact Div. of Cont. Ed., MCG, Augusta 30912. PH:404/828-3967.

MAY

2-5—*Sea Island:* **Georgia Society of Ophthalmology.** Category 1 credit. Contact Talitha Russell, MAG, 938 Peachtree St., NE, Atlanta 30309. PH:404/876-7535 or 1-800-282-0224 (toll free in Ga.).

3-4—*Atlanta:* **Second Annual Conference on Primary Care for the Underserved.** Category 1 credit. Contact Dir. of Med. Ed., Morehouse School of Medicine, 740 Westview Dr., SW, Atlanta 30314.

9-12—*Amelia Island, FL:* **Georgia Radiological Society Annual Meeting.** Category 1 credit. Contact Lloyd B. Schnuck, Jr., MD, 9 Medical Arts Ctr., Savannah 31405. PH:912/355-3642.

JUNE

10-13—*Kiawah Island, SC:* **16th Annual Internal Medicine Symposium.** Category 1 credit. Contact Div. of Cont. Ed., MCG, Augusta 30912. PH:404/828-3967.

14-16—*Hilton Head Island, SC:* **Georgia Society of Dermatologists Annual Meeting.** Category 1 credit. Contact Gerald Chotiner, MD, 3250 Howell Mill Rd., Atlanta 30327. PH:404/352-1730.

20-23—*Sea Island:* **Georgia Chapter, Amer. Acad. of Pediatrics Spring Meeting.** Category 1 credit. Contact William C. Mankin, Exec. Secy., Ga. Chapter, AAP, 4059 Land O'Lakes Dr., NE, Atlanta 30342. PH:404/237-3922.

WE WANT TO SERVE YOU BETTER!

Although we receive many notices for excellent continuing education meetings, all too often the information is received too late for timely inclusion in our Medical Meeting Calendar. In order for *your* meeting to be included, please send us the necessary information *two months* in advance of the issue in which you want it to appear. For example: for the August issue, copy is due by June 20; for the September issue, copy is due by July 20, etc. Mail to: Stephen Davis, Director of Education, MAG, 938 Peachtree St., NE, Atlanta, GA 30309.



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Finding Ways Through the Maze

by Steve Davis

MAG's Third Annual Leadership Conference will help you meet the challenges posed by the variety of medical practice options facing you now and in the future.

Our cover for this issue of the *Journal* calls attention to what physicians have known for quite a while — that the variety of medical practice options is presenting every Georgia doctor with a virtual maze of decisions. Not so long ago, physicians completing their training could assume they would enter into the private practice of medicine. In these days, however, the increasing role of reimbursers, cost containers, employers, and big health care corporations — not to mention an increasingly attentive government — has created a complex array of questions for the practitioner. Should I sign with an HMO? Will a PPO increase my patient load as promised, or am I just giving a 10% discount? Should I join my colleagues who are starting an IPA? Should I sign with Medicare as a participating physician? How do I deal with pressures about length of stay for my Medicare patients? Is "defensive medicine" the only answer to a worsening professional liability climate?

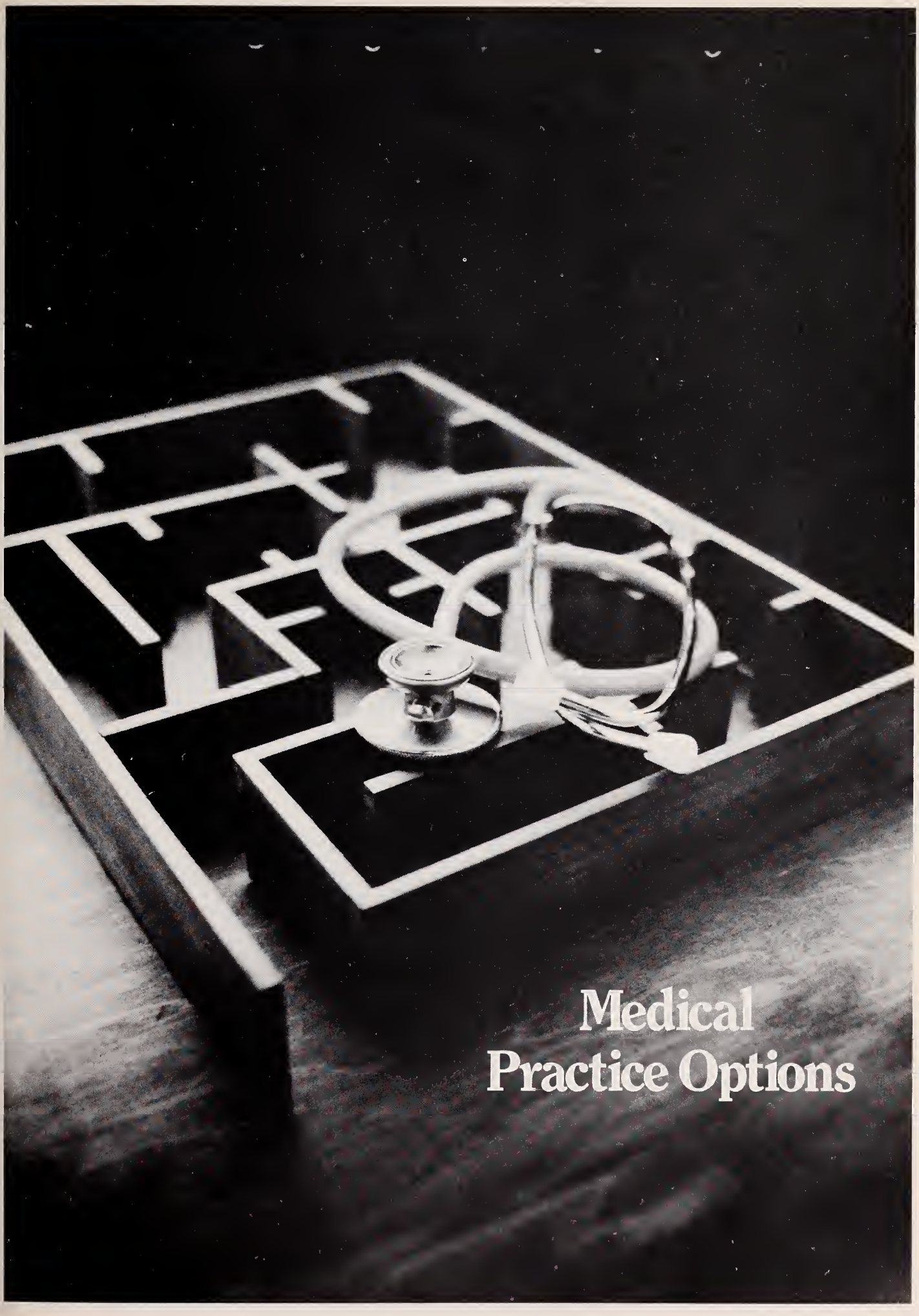
To answer some of these questions and to help you sort through the maze of issues they raise, the Medical Association of Georgia is sponsoring its Third Annual Leadership Conference, February 1-2, 1985, at the Waverly Hotel in Atlanta. For our faculty we have brought together informed experts, and we have provided plenty of time for our audience to discuss their concerns. Our meeting will be held all day on Friday, February 1, and in the morning of Saturday, the 2nd. Attendees of our highly successful 1984 Leadership Conference, held last January, will remember the Waverly Hotel in northwest Atlanta as a superb site for our conference.

This year we are charging a registration fee for our Leadership Conference — $50 for MAG members. We believe that after viewing our program, you will find this a modest price indeed for one of your most important meetings of the year.

Moderator on Friday will be MAG President Dr. Bill Clark, who will introduce E. Henry Lamkin, M.D., as our first speaker. In reviewing changes in our health care delivery system, Dr. Lamkin will bring together the perspectives of both physician and lawmaker. An internist in Indianapolis, Dr. Lamkin is a former Republican state representative and has served as Majority Leader of the Indiana House.

Next we want to bring our focus closer to home, with a slide presentation prepared by the MAG staff, on the status of medical care delivery in our state. Following that, some lively exchanges of opinion are expected from a panel of experts offering their perspectives on the delivery of care. Nathaniel Johnson, Vice President for Corporate Human Resources of Bell South Corporation, will represent employers and payors. The administrator of a not-for-profit hospital, Charles L. Foster, Jr., of the West Georgia Medical Center in LaGrange, will trade viewpoints with Ernest Bacon, administrator of West Paces Ferry Hospital. Rounding out our panel will be a representative of the physician in private practice, W. John O'Shaughnessey, Jr., M.D., of Macon. Dr. O'Shaughnessey has addressed several previous MAG gatherings on the effectiveness of voluntary efforts by physicians to curb costs.

After lunch on Friday we plan for Rep. W. Henson Moore to review the role of the federal government in health care, and its outlook in the near future. Then, "Challenges You Are Facing Today" will be the theme for the rest of the afternoon. Harry Schwartz, Ph.D., will present the current "pros" and "cons" of private practice and how it is being affected by concern for cost effectiveness. Dr. Schwartz has written extensively on medical economics for *Private Practice, Wall Street Journal,* and other well-known publications. Health care financing will be the topic of John C. Goodman, Ph.D., who is president of the National Center for Policy Analysis, and a professor of economics at the University of Dallas. Then, the


Medical
Practice Options

stressful climate of professional liability insurance will be explained by James S. Todd, M.D., who is President of the Physician Insurors Association of America, the organization of physician-owned professional liability insurance companies.

After short presentations, each of these speakers will lead an in-depth examination of his topic in "break-out" sessions. At the end of the afternoon, all conference attendees and their spouses are cordially invited to a reception at the Waverly, from 6:00 to 7:30 p.m.

On Saturday morning, Stephen Falken, Ph.D., will awaken us with his comments on how physicians can best deal with the changes affecting our lives and practice. Dr. Falken has addressed similar themes at the Leadership Conference of the Pennsylvania Medical Society and other professional groups.

A major emphasis of the Leadership Conference will be not just to identify critical issues but also to provide answers as well. Saturday morn-

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"CHALLENGES FOR TODAY'S PHYSICIAN"

Third Annual MAG Leadership Conference
February 1-2, 1985
Waverly Hotel
Atlanta

FRIDAY, FEBRUARY 1

MODERATOR .....
S. William Clark, Jr., M.D.,
President,
Medical Association of Georgia

9:00-9:10 INTRODUCTION .....
S. William Clark, Jr., M.D.

9:10-9:45 IS AMERICA MARCHING TO MEDICAL MEDIOCRITY? .....
E. Henry Lamkin, M.D.

9:45-10:00 QUESTIONS AND DISCUSSION

10:00-10:15 COFFEE BREAK

10:15-10:30 THE MEDICAL MARKETPLACE IN GEORGIA
MAG SLIDE PRESENTATION
Introduced by Dr. Clark

10:30-11:30 PERSPECTIVES ON THE DELIVERY OF CARE
10:30 ..... Employers & Payors
Nathaniel Johnson
10:45 ... Investor-owned Facilities
Ernest Bacon
11:00 .... Not-For-Profit Hospitals
Charles L. Foster
11:15 ..... Private Physician
W. John O'Shaughnessey, Jr., M.D.

11:30-12:00 QUESTIONS & DISCUSSION

12:00-1:30 LUNCH (on your own)

1:30-2:15 THE GOVERNMENT AND MEDICINE: WHAT'S NEXT? .....
Rep. W. Henson Moore

2:15-2:30 COFFEE BREAK

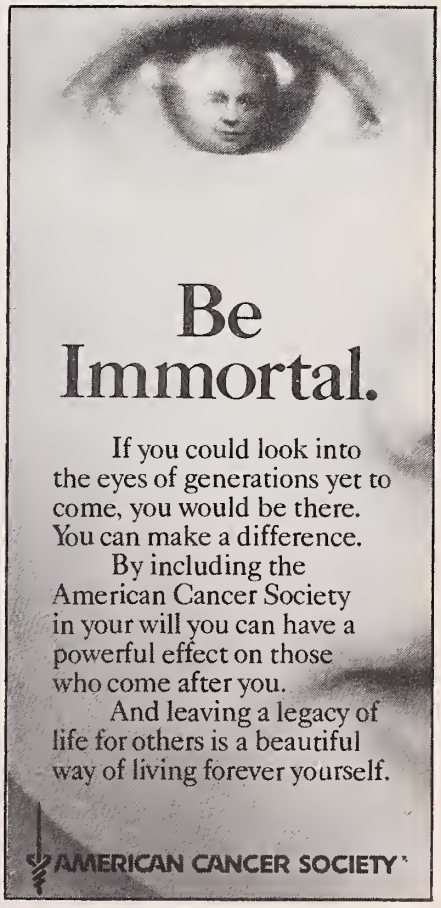
2:30-3:15	FACING THE CHALLENGES OF PRACTICE
	2:30 ..... Private Practice: Is Economics The Bottom Line? Harry Schwartz, Ph.D.
	2:45 ..... Health Care Financing: Prospects For Change John Goodman, Ph.D.
	3:00 ..... Professional Liability: Can You Continue To Practice? James S. Todd, M.D.
3:15-4:30	QUESTIONS & DISCUSSION IN "BREAKOUT" SESSIONS
	A..... Dr. Schwartz
	B..... Dr. Goodman
	C..... Dr. Todd
6:00-7:30	RECEPTION

SATURDAY, FEBRUARY 2

	MODERATOR ..... William D. Logan, Jr., M.D., President-elect, Medical Association of Georgia
9:00-9:05	INTRODUCTION ..... William D. Logan, Jr., M.D.
9:05-9:30	HOW CAN PHYSICIANS DEAL WITH CHANGE? ..... Stephen Falken, Ph.D.
9:30-10:00	"SURVIVAL SKILLS" FOR PHYSICIANS
	9:30 ..... Marketing Your Private Practice Andrew P. Morley, M.D.
	9:45 ..... Contracting Skills For Physicians Jack C. Wood, J.D.
10:00-11:30	QUESTIONS AND DISCUSSION IN "BREAKOUTS"
	A..... Dr. Morley
	B..... Mr. Wood
11:30-12:00	STATUS REPORT: THE ROLE OF MAG
12:00	ADJOURNMENT

ing for the most part will therefore be spent on techniques which physicians may use in dealing with the increasingly competitive medical marketplace. Leading off this "Survival Skills" session, and addressing the topic of "Marketing Your Private Practice" will be Andrew Morley, M.D., family physician from Decatur who has become a nationally-known expert on medical marketing. Then, to provide physicians with information on contracting one's medical practice, Jack C. Wood, J.D., of Cripple Creek, Colorado, will follow. Mr. Wood's law firm has made significant study of physician, hospital, and third party relationships, and has represented a large number of physician groups, including state and national medical societies.

Concluding the Leadership Conference on Saturday will be a status report on MAG's possible role in the medical marketplace of Georgia. Afterwards, the Conference will adjourn at noon. We believe that this day-and-a-half meeting is one of MAG's best yet. All members are encouraged to attend. Consider that maze of practice options — the 1985 MAG Leadership Conference will help you find your way through!





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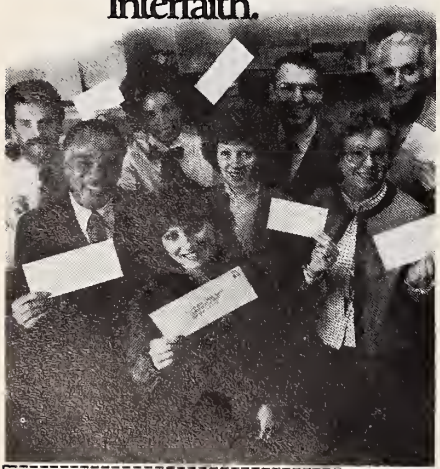
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Mark Your Calendar Now! MAG Leadership Conference 1985

Dates:	**February 1-2, 1985 (Friday 9:00 am-4:30 pm, with reception 6:00-7:30; and Saturday 9:00 am-12:00 noon)**
Location:	**The Waverly Hotel I-285 and U.S. 41 (northwest of Atlanta)**
Registration Fee:	**$50.00—MAG member $150.00—non-member physician**
How to Register:	**A registration form will be mailed to you. Use it to reserve your place at the Leadership Conference.**

"IT'S WHAT SMOKING DOES TO YOUR LOOKS THAT KILLS ME."

"I don't even like to be in a room with people who are smoking. Especially after I've just washed my hair. Or bothered to get all dressed up."

"Besides, I think smoking ruins your image. It's almost like wearing a sign that says you don't feel secure enough to go without cigarettes."

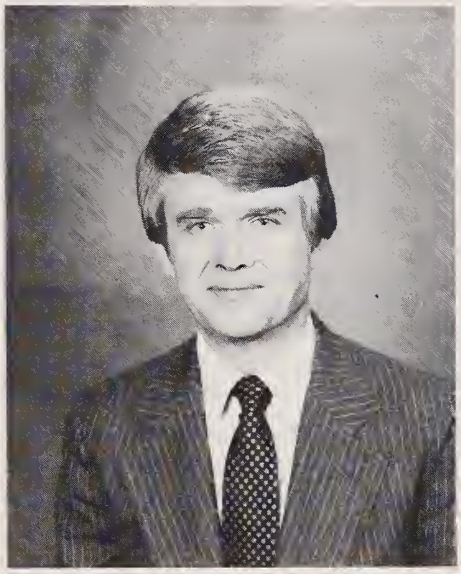


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Conference Speakers



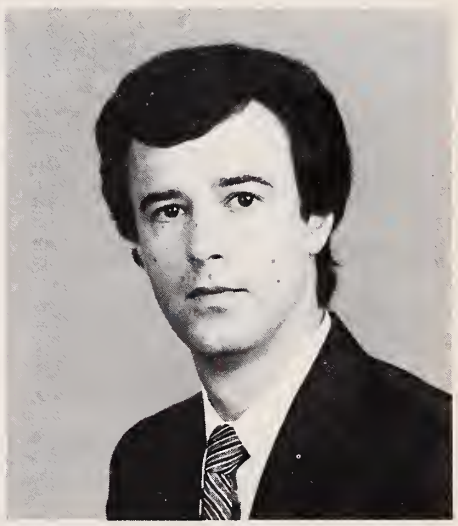
Attorney Jack C. Wood, of Cripple Creek, Colorado, is an expert on physician, hospital, and third-party relationships. His firm of Wood, Lucksinger, & Epstein has represented a number of medical associations, hospital medical staffs, and individual physician groups.



Andrew P. Morley, Jr., M.D., family physician practicing in Decatur, has become a nationally recognized authority on medical marketing. On Saturday morning, he will lead a session about how physicians can promote their practices in the present era of competition.



W. John O'Shaughnessey, Jr., M.D., of Macon, specializes in internal medicine and pulmonary disease. On Friday, he will represent practicing physicians in a panel discussing different perspectives on the delivery of medical care.



John C. Goodman, Ph.D., is President of the National Center for Policy Analysis, a Dallas based think tank. He is the author of National Health Care in Great Britain, *and is an expert on the impact of government policies on health care.*



Steven Falken, Ph.D., a former Wall Street economist, has spoken to associations and businesses across the country on how to use change to their advantage, capitalizing on new opportunities.



Nathaniel R. Johnson, a vice president for BellSouth Corporation, is chairman of the Board of the Greater Atlanta Coalition on Health Care, Inc. He will participate in the "perspectives" panel on Friday morning.



Harry Schwartz, Ph.D., is a prolific columnist on medical topics and author of The Case for American Medicine. *On Friday afternoon, he will offer his insights on the economic forces shaping private practice today.*



The new Georgia Heart Clinic in LaGrange could be viewed as a model for national solutions to medical care delivery problems.

From the Heart

Dedication Speech for the Georgia Heart Clinic

DANIEL D. FEDERMAN, M.D., *Boston, Massachusetts**

Introduction

GOVERNOR HARRIS, Mr. Calloway, Dr. Copeland, Ladies and Gentlemen: It is a great honor for me to be asked to participate in this happy day, the dedication of the Georgia Heart Clinic. I can think of few more joyous occasions than the opening of a first-class facility for medical care that represents a combination of private support and community recognition of the public service of its physicians. But while I would like to spend my time with you in pure celebration, it would be foolish to deny that important problems face modern medicine in America. So I am going to spend the first part of my talk discussing what I see as the five major influences on health care and medicine in the coming years. As you will quickly see, each is a problem that the profession and the public it serves must work on together.

Challenges and Influences

The first great challenge and influence is the aging of the population. The group of our citizens over 65 is now the most rapidly growing portion of the population. While in many ways this reflects a medical and social triumph, it also presents special challenges to health care. Ironically, one of these challenges derives from the very fact that the great majority of these individuals are very healthy. They need a chance to lead productive lives free of the prejudice and assumption of illness that often surround older individuals.

Nevertheless, many older individuals have chronic disorders rather than a single acute one. Often, several diseases coexist in one person, and both the conditions and their treatments influence each other. There are also changes in the families of geriatric patients. The American family is smaller and more dispersed than it used to be, and less prepared to provide home support. Yet the opportunities for home care of seriously ill patients are growing: all of us must recognize the challenge to provide effective community expression of the doctor's orders.

A second large problem at the present time is the maldistribution of health manpower. Although

* Dr. Federman is Professor of Medicine and Dean for Students and Alumni, Harvard Medical School, 25 Shattuck St., Boston, MA 02115. Send reprint requests to him.

This speech was given at the dedication ceremonies of the Georgia Heart Clinic in LaGrange on April 7, 1984, and is available on video cassette. For information about the video cassette, contact Robert Copeland, M.D., Director, Georgia Heart Clinic, 1514 Vernon Rd., LaGrange, GA 30241

many data suggest that there will be a glut of physicians by 1990, I prefer today to talk about two *current* problems in health manpower. One is the geographic maldistribution of physicians. For various reasons, America now has an excess of physicians in well-to-do neighborhoods in our cities and their immediate suburbs, but has a deficiency of physicians in many rural areas and virtually all inner city areas. In other words, 5 years away from a predicted absolute excess of physicians, we still have important segments of our citizenry unserved by physicians with modern training.

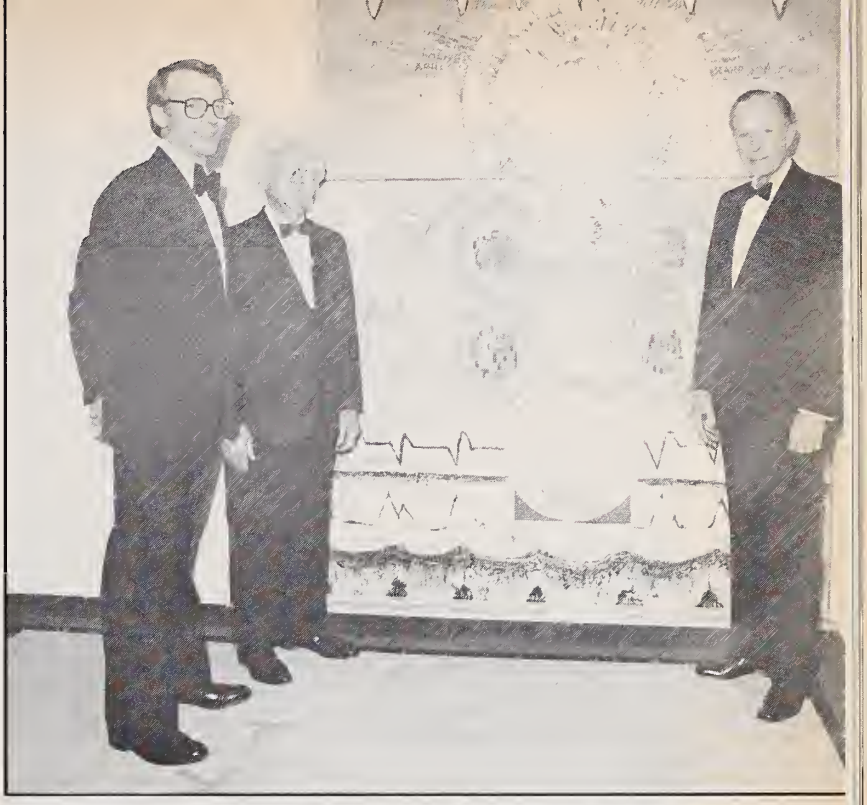
. . . a first-class facility for medical care that represents a combination of private support and community recognition of the public service of its physicians.

A second component of the manpower problem is the specialty maldistribution. For approximately 15 years, the graduates of our medical schools and training hospitals have disproportionately chosen specialty practice. As a result, for most of the country there are more neurosurgeons, ophthalmologists, cardiologists, and orthopedists than are truly needed, whereas there is a deficiency in the number of general internists and primary care physicians such as family practitioners and pediatricians.

The third major and quite mixed influence on our future is the progress in science. Within the past 20 years, and accelerating at present, there has been the most extraordinary progress in basic science underlying medicine that one can imagine. This is the best time in the history of man to be a doctor — that is, to prepare for a life of service to patients using the progress in science. But it is also a difficult time because of the challenge of keeping up with what's going on and of avoiding obsolescence of the knowledge you have.

The fourth problem that I wish to refer to is the progress of technology. Now, ordinarily science and technology are linked. But in medicine, there are three special features about technology that are worth mentioning. First, technologic progress often proceeds scientific progress. An example would be renal dialysis such as is available for patients with kidney failure here in LaGrange through the West Georgia Medical Center. We don't know much about the causes of renal failure, but we do know that we can treat it or substitute for the kidney by the use of the dialysis machine. This is an example of what Dr. Lewis Thomas has called high technology and low science.

A second feature about medical technology is that it often is very expensive. Unlike other fields, advances in medical technology don't seem to save



Lamar Dodd painted The Heart of Man *when the officers of the Georgia Heart Clinic asked him to help commemorate the great interest in medicine and the great philanthropy of Fuller E. Callaway, Jr. Standing left to right are: Dr. Robert Copeland, director of the Clinic; Mr. Dodd, Professor Emeritus of Art and Chairman Emeritus of the Fine Arts Division of the University of Georgia; and Mr. Callaway whose wise counsel and support have been critically important to the Clinic from its inception.*

manpower or costs. Rather, the application of such advances to the care of ill patients seems to require expensive instrumentation and new manpower, with a consequent drive to increase costs.

The Clinic provides a remarkable range of modern technology. . . .

The third consequence of technologic progress that represents a burden is its risk to the health of individuals who are subjected to complex procedures. Although it would seem natural to expect benefit, many of the advanced technologic procedures are somewhat risky and thus have a price of their own, particularly when inappropriately applied.

The last of the influences to which I will refer is the burden of health care costs. Hospitalization in tertiary care settings, complex technology, the cost of powerful modern drugs, and physicians' fees all add up to an expense now equal to 10 cents on every earned American dollar. While many individuals see nothing wrong with our committing that much to health care — and while I happen to be among those — the general public perception, including that of our congressmen and the Executive Branch of the federal government is that costs are out of bounds

and must be contained. Both for the society and for the individual, there is a perception that we are spending too much and must make choices.

Creative Solutions

Now you may well be asking yourself why on this happy day is this visitor from the North belaying us with such a sorry litany. Why is he focusing on problems and challenges rather than recognizing a moment of joy? In short, why this lamentation when reveling would be more appropriate? Well, I have chosen this approach for a very special reason. For creative people, every problem should be looked upon as an opportunity. And as I consider the full promise of the Georgia Heart Clinic, I think you should look on it as a model for national solutions to problems that are universal and not specific to LaGrange. Let me then repeat the five problems we've just looked at and indicate the ways in which I feel this grand new facility will provide portions of a solution.

For the care of an aging population, the Georgia Heart Clinic will be able to provide services near home. For many individuals who would otherwise have to make the trek to Atlanta or to Birmingham, separating them from their families, or requiring a temporary but expensive dislocation, the services available in tertiary centers are now largely available here.

Second, the Georgia Heart Clinic will stress ambulatory care and preventive medicine, with a particular focus on preventive cardiology. Since cardiovascular disease remains the major threat to older individuals, right here in this facility you have addressed some of the principal problems of the care of geriatric patients.

For creative people, every problem should be looked upon as an opportunity.

In the area of health manpower, I spoke of geographic and specialty maldistribution. The progress in the West Georgia Medical Center and in the Georgia Heart Clinic clearly demonstrates that a small community can attract and sustain the appropriate mix of specialized services. You have shown that physicians who require advanced technology can find everything they need to do their job here. But even more, you have created a setting where general internists and family physicians and pediatricians can work directly with specialists to bring the most sophisticated care to seriously ill patients. It is exactly this balance and cooperative application of specialist and generalist effort that ultimately provides good care.



Leaders of the dedication ceremonies of the Georgia Heart Clinic are shown after the ribbon was cut celebrating the opening of the new $3.5 million expansion. Left to right are: Dr. Robert Copeland, director of the Clinic; Dr. Daniel Federman, Dean of Harvard Medical School, and Governor Joe Frank Harris, both speakers at the dedication; and Mayor Gardner Newman.

In a similar vein, the progress in science here becomes an opportunity and a promise rather than a problem. The Heart Clinic will have some areas dedicated to research; you have already obtained grant support and published scientific articles based on the patient population and types of physicians available here. You bring to the Clinic a fellow from the Cardiac Division at the University of Alabama, Birmingham. This individual, close to the progress in science in the university, is able to bring that kind of insight to the care of your patients here and, in a reciprocal way, can bring an awareness of problems of patients to the scientists doing the basic research in the University. This clinic also provides a locus for continuing medical education, because with the facilities and persons you have here, you are able to attract lecturers and scholars from other areas to talk about the progress in their own research that might be of use in the care of patients in LaGrange.

The progress in technology, which I previously referred to as a problem, here becomes an opportunity. The Clinic provides a remarkable range of modern technology, including some facilities that are not currently available at the Massachusetts General Hospital or at the Brigham and Womens Hospital where I work. And, most important, you have brought that technology to where the patients are. In other words, it is no longer necessary for patients in this area to leave and go to university

centers; they can find all the technologic investigation they need right here. What's more, they can find this technology at the site where both their primary physicians and specialists can be involved in their care. This minimizes the big risk I mentioned earlier, that the technology will be used in a risky manner insensitive to the needs of the particular person. Where specialists and referring physician work together, where the family and the patient can be in on the choices to be made, technology becomes a brilliant expression of scientific and clinical excellence.

I think you should look on the Georgia Heart Clinic as a model for national solutions to [medical care delivery] problems that are universal and not specific to LaGrange.

And finally, health care costs. It would be disingenuous of me to pretend that the Georgia Heart Clinic will solve the problem of health care costs that has daunted our entire profession and country. But there are some components of a solution. Community-based care, making referral less frequently needed, has been shown to be cost effective in many studies. The emphasis on prevention and early diagnosis reduces the need for costly hospitalization. The availability of technology facilitates both access and scheduling and improves communication among those who do and those who need the procedures. Finally, the close association of primary physicians and technologically supported specialists minimizes the risk from inappropriately applied technology.

Lastly, the Georgia Heart Clinic represents something which in the long run is the least expensive — quality care. Numerous studies, including research conducted by the American Board of Internal Medicine, has shown that for complex illness, the best care is simultaneously the least expensive.

Summing Up

Let me conclude with a very simple statement. I began by outlining five major problems facing our healthcare system. I concluded by stating that creative people make problems into opportunities. I am convinced and indeed inspired that the facilities of the Georgia Heart Clinic, the generosity of its private supporters, and the quality of its physicians are combining to bring you in this area the finest of health care. Even more, you are bringing to the country at large a shining example of how to meet and solve some of our biggest health care problems. It has thus been a great pleasure and a personal privilege for me to help you in dedicating this institution.



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The recruitment program serves to influence those minority students who are accepted for the medical curriculum to enroll at MCG. . . .

Recruitment: For Minority Students By Minority Students

VERA B. THURMOND, ED.D., and MILLARD COLLIER, M.D., *Augusta**

Background

Recruitment of minority students is an important factor in increasing minority enrollment in medical schools. This report describes a recruitment program initiated by the Student National Medical Association (SNMA), a black student organization, to recruit other black students to their campus at the Medical College of Georgia (MCG).

The SNMA did not feel capable of making a significant change in the overall applicant pool, but felt that they could increase the number of enrolled minority students by working with the existing applicant pool. Because of a decline in the national pool of qualified black applicants, there has been a noticeable tendency of Georgia residents to attend medical college outside the state and therefore not return to the state to practice. The SNMA's recruitment program serves to influence those minority students who are accepted for the medical curriculum to enroll at MCG and increase the likelihood of these students practicing in Georgia, where blacks comprise 30 percent of the population but only 1 percent of the practicing physicians.

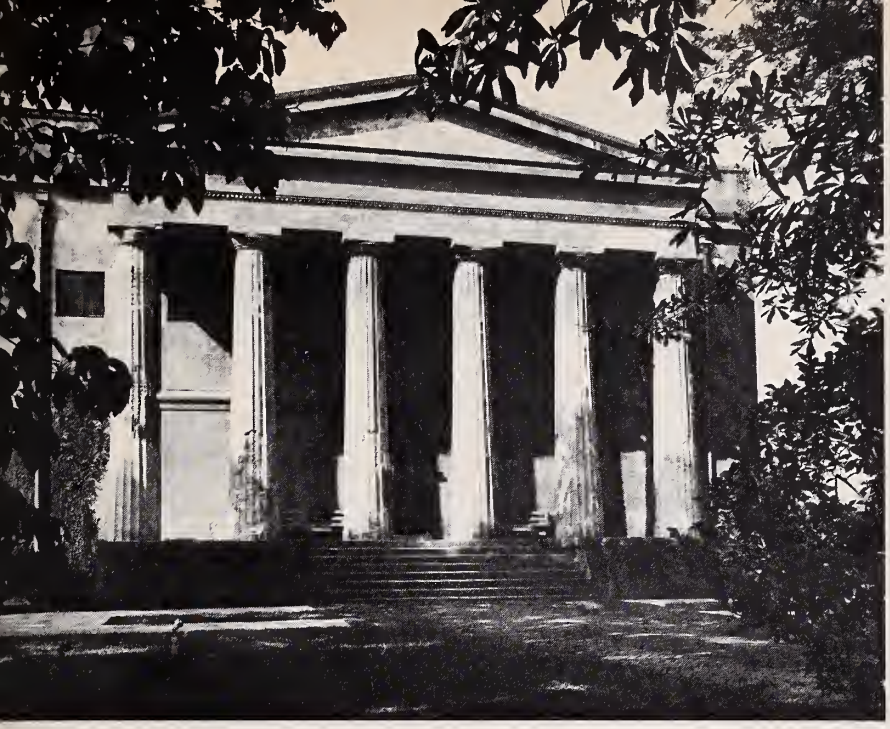
The recruitment program is unique because it involves minority students in the recruitment of other minority students. The program operates on a premise held by the minority medical students. The students believe that personal contact between students of similar cultural background is important in providing minority students with information on the academic and social environment. This information is evidently used by minority medical applicants to choose the best medical school for them. The SNMA also believes personal relationships and a family-like environment will encourage black students (many who come from rural towns and small, predominantly black colleges) to attend MCG.

Description

The SNMA recruitment program works smoothly with the cooperation of the admissions office and the Student Educational Enrichment Programs (SEEP), a special program concerned with the recruitment and retention of minority students. Because students share the responsibilities, the program does not consume too much time of any one medical student. The program is also cost efficient. The only expenditure is for mail and phone calls. Basically, there is a series of communication and personal contacts between the applicant and SNMA members. The following is typical of the sequence of events:

1) The SNMA president is notified of impending interviews of minority applicants by the office of SEEP. Name, address, phone number, and college are provided.
2) A letter is sent to the prospective interviewee. The first letter introduces the SNMA host, invites the student to come the evening before the interview, and offers overnight accommodations.
3) The host's responsibilities include providing the applicant a prospective on MCG (its history, etc.), explaining the interview process, having breakfast with the interviewee to decrease anxiety, and arranging for the interviewee to have lunch with a group of SNMA members.
4) On the day of the interview, the minority applicant is directed by the SNMA host to meet with

* Dr. Thurmond is Associate Director of the Student Educational Enrichment Programs at the Medical College of Georgia, and Dr. Collier, a recent graduate of MCG and former President of the Student National Medical Association, is doing his residency in family practice at Morehouse School of Medicine in Atlanta. Send reprint requests to Dr. Thurmond at Student Educational Enrichment Programs, Room AA-153, Medical College of Georgia, Augusta, Georgia 30912.



The Old Medical College, Augusta

the Director of Minority Affairs and the Directors of SEEP. Students are informed about financial aid arrangements in these two offices and the Office of Financial Aid.

5) A post-interview letter is sent to each applicant. This letter thanks the student for coming and encourages continued communication between the applicant, the SNMA students, and appropriate MCG offices.
6) A third letter is sent to each applicant. If the student is accepted, the letter is one of congratulations with a reminder about the programs at MCG, including housing and financial aid. These students are invited in a group to visit the MCG campus, to monitor classes for a full day with a SNMA host and participate in a luncheon with other accepted minority applicants and SNMA members. Students not accepted are finally mailed a letter of regrets with wishes for continued success.
7) Immediately after a minority student is accepted, a SNMA member becomes the student's "big brother" or "big sister." The big brother or big sister continues to communicate with the applicant and helps in the transition from college to medical school. The brother/sister relationship is expected to continue once the student enters the curriculum.

Evaluation

The SNMA recruitment program has been in effect 2 years, probably not enough time from which to make long-term predictions. However, positive changes have been noticed, and the enthusiasm of the students remains high. Previously, only 50 percent or less of the minority applicants accepted at MCG chose to enroll. Others would enroll at other institutions. For the 1983 entering class, 70 percent of the black students accepted are matriculating.

". . . produce an increasing number of particularly sensitive and excellent physicians to serve minority and indigent communities."

Sixty-two percent of the accepted black students enrolled in the 1984 entering class. This was considered significant, since many of these students had multiple acceptances. Several of the minority freshman students have commented on the effectiveness of the program. One freshman student stated: "The friendly atmosphere projected by the other minority students is what influenced me to attend this school."

Discussion

The SNMA Chapter at MCG is one of 114 chartered chapters in every medical school where minority medical students are enrolled. One of the missions of SNMA is to "produce an increasing number of particularly sensitive and excellent physicians to serve minority and indigent communities." The MCG Chapter has capsulized this mission to increasing the number trained at the state medical school. They attempt to encourage the minority applicant by providing a warm atmosphere of friendly relationships with successful role models who are also peers. This recruitment activity is one that can be used by minority medical students or any student medical group interested in recruiting minority students.

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References:
1. Strauss WE, McIntyre KM, Parisi AF, et al: Safety and efficacy of diltiazem hydrochloride for the treatment of stable angina pectoris: Report of a cooperative clinical trial. Am J Cardiol 49:560-566, 1982.
2. Pool PE, Seagren SC, Bonanno JA, et al: The treatment of exercise-inducible chronic stable angina with diltiazem: Effect on treadmill exercise. Chest 78 (July suppl):234-238, 1980.

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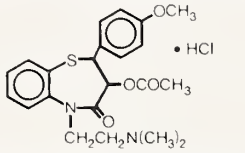
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CLINICAL PHARMACOLOGY

The therapeutic benefits achieved with CARDIZEM are believed to be related to its ability to inhibit the influx of calcium ions during membrane depolarization of cardiac and vascular smooth muscle.

Mechanisms of Action. Although precise mechanisms of its antianginal actions are still being delineated, CARDIZEM is believed to act in the following ways:

1. Angina Due to Coronary Artery Spasm: CARDIZEM has been shown to be a potent dilator of coronary arteries both epicardial and subendocardial. Spontaneous and ergonovine-induced coronary artery spasm are inhibited by CARDIZEM.
2. Exertional Angina: CARDIZEM has been shown to produce increases in exercise tolerance, probably due to its ability to reduce myocardial oxygen demand. This is accomplished via reductions in heart rate and systemic blood pressure at submaximal and maximal exercise work loads.

In animal models, diltiazem interferes with the slow inward (depolarizing) current in excitable tissue. It causes excitation-contraction uncoupling in various myocardial tissues without changes in the configuration of the action potential. Diltiazem produces relaxation of coronary vascular smooth muscle and dilation of both large and small coronary arteries at drug levels which cause little or no negative inotropic effect. The resultant increases in coronary blood flow (epicardial and subendocardial) occur in ischemic and nonischemic models and are accompanied by dose-dependent decreases in systemic blood pressure and decreases in peripheral resistance.

Hemodynamic and Electrophysiologic Effects. Like other calcium antagonists, diltiazem decreases sinoatrial and atrioventricular conduction in isolated tissues and has a negative inotropic effect in isolated preparations. In the intact animal, prolongation of the AH interval can be seen at higher doses.

In man, diltiazem prevents spontaneous and ergonovine-provoked coronary artery spasm. It causes a decrease in peripheral vascular resistance and a modest fall in blood pressure and, in exercise tolerance studies in patients with ischemic heart disease, reduces the heart rate-blood pressure product for any given work load. Studies to date, primarily in patients with good ventricular function, have not revealed evidence of a negative inotropic effect; cardiac output, ejection fraction, and left ventricular end diastolic pressure have not been affected. There are as yet few data on the interaction of diltiazem and beta-blockers. Resting heart rate is usually unchanged or slightly reduced by diltiazem.

Intravenous diltiazem in doses of 20 mg prolongs AH conduction time and AV node functional and effective refractory periods approximately 20%. In a study involving single oral doses of 300 mg of CARDIZEM in six normal volunteers, the average maximum PR prolongation was 14% with no instances of greater than first-degree AV block. Diltiazem-associated prolongation of the AH interval is not more pronounced in patients with first-degree heart block. In patients with sick sinus syndrome, diltiazem significantly prolongs sinus cycle length (up to 50% in some cases).

Chronic oral administration of CARDIZEM in doses of up to 240 mg/day has resulted in small increases in PR interval, but has not usually produced abnormal prolongation. There were, however, three instances of second-degree AV block and one instance of third-degree AV block in a group of 959 chronically treated patients.

Pharmacokinetics and Metabolism. Diltiazem is absorbed from the tablet formulation to about 80% of a reference capsule and is subject to an extensive first-pass effect, giving an absolute bioavailability (compared to intravenous dosing) of about 40%. CARDIZEM undergoes extensive hepatic metabolism in which 2% to 4% of the unchanged drug appears in the urine. In vitro binding studies show CARDIZEM is 70% to 80% bound to plasma proteins. Competitive ligand binding studies have also shown CARDIZEM binding is not altered by therapeutic concentrations of digoxin, hydrochlorothiazide, phenylbutazone, propranolol, salicylic acid, or warfarin. Single oral doses of 30 to 120 mg of CARDIZEM result in detectable plasma levels within 30 to 60 minutes and peak plasma levels two to three hours after drug administration. The plasma elimination half-life following single or multiple drug administration is approximately 3.5 hours. Desacetyl diltiazem is also present in the plasma at levels of 10% to 20% of the parent drug and is 25% to 50% as potent a coronary vasodilator as diltiazem. Therapeutic blood levels of CARDIZEM appear to be in the range of 50 to 200 ng/ml. There is a departure from dose-linearity when single doses above 60 mg are given; a 120-mg dose gave blood levels three times that of the 60-mg dose. There is no information about the effect of renal or hepatic impairment on excretion or metabolism of diltiazem.

INDICATIONS AND USAGE

1. **Angina Pectoris Due to Coronary Artery Spasm.** CARDIZEM is indicated in the treatment of angina pectoris due to coronary artery spasm. CARDIZEM has been shown effective in the treatment of spontaneous coronary artery spasm presenting as Prinzmetal's variant angina (resting angina with ST-segment elevation occurring during attacks).
2. **Chronic Stable Angina (Classic Effort-Associated Angina).** CARDIZEM is indicated in the management of chronic stable angina. CARDIZEM has been effective in controlled trials in reducing angina frequency and increasing exercise tolerance.

There are no controlled studies of the effectiveness of the concomitant use of diltiazem and beta-blockers or of the safety of this combination in patients with impaired ventricular function or conduction abnormalities.

CONTRAINDICATIONS

CARDIZEM is contraindicated in (1) patients with sick sinus syndrome except in the presence of a functioning ventricular pacemaker, (2) patients with second- or third-degree AV block except in the presence of a functioning ventricular pacemaker, and (3) patients with hypotension (less than 90 mm Hg systolic).

WARNINGS

1. **Cardiac Conduction.** CARDIZEM prolongs AV node refractory periods without significantly prolonging sinus node recovery time, except in patients with sick sinus syndrome. This effect may rarely result in abnormally slow heart rates (particularly in patients with sick sinus syndrome) or second- or third-degree AV block (six of 1243 patients for 0.48%). Concomitant use of diltiazem with beta-blockers or digitalis may result in additive effects on cardiac conduction. A patient with Prinzmetal's angina developed periods of asystole (2 to 5 seconds) after a single dose of 60 mg of diltiazem.
2. **Congestive Heart Failure.** Although diltiazem has a negative inotropic effect in isolated animal tissue preparations, hemodynamic studies in humans with normal ventricular function have not shown a reduction in cardiac index nor consistent negative effects on contractility (dp/dt). Experience with the use of CARDIZEM alone or in combination with beta-blockers in patients with impaired ventricular function is very limited. Caution should be exercised when using the drug in such patients.
3. **Hypotension.** Decreases in blood pressure associated with CARDIZEM therapy may occasionally result in symptomatic hypotension.
4. **Acute Hepatic Injury.** In rare instances, patients receiving CARDIZEM have exhibited reversible acute hepatic injury as evidenced by moderate to extreme elevations of liver enzymes. (See PRECAUTIONS and ADVERSE REACTIONS.)

PRECAUTIONS

General. CARDIZEM (diltiazem hydrochloride) is extensively metabolized by the liver and excreted by the kidneys and in bile. As with any new drug given over prolonged periods, laboratory parameters should be monitored at regular intervals. The drug should be used with caution in patients with impaired renal or hepatic function. In subacute and chronic dog and rat studies designed to produce toxicity, high doses of diltiazem were associated with hepatic damage. In special subacute hepatic studies, oral doses of 125 mg/kg and higher in rats were associated with histological changes in the liver which were reversible when the drug was discontinued. In dogs, doses of 20 mg/kg were also associated with hepatic changes; however, these changes were reversible with continued dosing.

Drug Interaction. Pharmacologic studies indicate that there may be additive effects in prolonging AV conduction when using beta-blockers or digitalis concomitantly with CARDIZEM. (See WARNINGS).

Controlled and uncontrolled domestic studies suggest that concomitant use of CARDIZEM and beta-blockers or digitalis is usually well tolerated. Available data are not sufficient, however, to predict the effects of concomitant treatment, particularly in patients with left ventricular dysfunction or cardiac conduction abnormalities. In healthy volunteers, diltiazem has been shown to increase serum digoxin levels up to 20%.

Carcinogenesis, Mutagenesis, Impairment of Fertility. A 24-month study in rats and a 21-month study in mice showed no evidence of carcinogenicity. There was also no mutagenic response in in vitro bacterial tests. No intrinsic effect on fertility was observed in rats.

Pregnancy. Category C. Reproduction studies have been conducted in mice, rats, and rabbits. Administration of doses ranging from five to ten times greater (on a mg/kg basis) than the daily recommended therapeutic dose has resulted in embryo and fetal lethality. These doses, in some studies, have been reported to cause skeletal abnormalities. In the perinatal/postnatal studies, there was some reduction in early individual pup weights and survival rates. There was an increased incidence of stillbirths at doses of 20 times the human dose or greater.

There are no well-controlled studies in pregnant women; therefore, use CARDIZEM in pregnant women only if the potential benefit justifies the potential risk to the fetus.

Nursing Mothers. It is not known whether this drug is excreted in human milk. Because many drugs are excreted in human milk, exercise caution when CARDIZEM is administered to a nursing woman if the drug's benefits are thought to outweigh its potential risks in this situation.

Pediatric Use. Safety and effectiveness in children have not been established.

ADVERSE REACTIONS

Serious adverse reactions have been rare in studies carried out to date, but it should be recognized that patients with impaired ventricular function and cardiac conduction abnormalities have usually been excluded.

In domestic placebo-controlled trials, the incidence of adverse reactions reported during CARDIZEM therapy was not greater than that reported during placebo therapy.

The following represent occurrences observed in clinical studies which can be at least reasonably associated with the pharmacology of calcium influx inhibition. In many cases, the relationship to CARDIZEM has not been established. The most common occurrences, as well as their frequency of presentation, are: edema (2.4%), headache (2.1%), nausea (1.9%), dizziness (1.5%), rash (1.3%), asthenia (1.2%), AV block (1.1%). In addition, the following events were reported infrequently (less than 1%) with the order of presentation corresponding to the relative frequency of occurrence.

Cardiovascular:	Flushing, arrhythmia, hypotension, bradycardia, palpitations, congestive heart failure, syncope.
Nervous System:	Paresthesia, nervousness, somnolence, tremor, insomnia, hallucinations, and amnesia.
Gastrointestinal:	Constipation, dyspepsia, diarrhea, vomiting, mild elevations of alkaline phosphatase, SGOT, SGPT, and LDH.
Dermatologic:	Pruritus, petechiae, urticaria, photosensitivity.
Other:	Polyuria, nocturia.

The following additional experiences have been noted:

A patient with Prinzmetal's angina experiencing episodes of vasospastic angina developed periods of transient asymptomatic asystole approximately five hours after receiving a single 60-mg dose of CARDIZEM.

The following postmarketing events have been reported infrequently in patients receiving CARDIZEM: erythema multiforme; leukopenia; and extreme elevations of alkaline phosphatase, SGOT, SGPT, LDH, and CPK. However, a definitive cause and effect between these events and CARDIZEM therapy is yet to be established.

OVERDOSAGE OR EXAGGERATED RESPONSE

Overdosage experience with oral diltiazem has been limited. Single oral doses of 300 mg of CARDIZEM have been well tolerated by healthy volunteers. In the event of overdosage or exaggerated response, appropriate supportive measures should be employed in addition to gastric lavage. The following measures may be considered:

Bradycardia	Administer atropine (0.60 to 1.0 mg). If there is no response to vagal blockade, administer isoproterenol cautiously.
High-Degree AV Block	Treat as for bradycardia above. Fixed high-degree AV block should be treated with cardiac pacing.
Cardiac Failure	Administer inotropic agents (isoproterenol, dopamine, or dobutamine) and diuretics.
Hypotension	Vasopressors (eg, dopamine or levarterenol bitartrate).

Actual treatment and dosage should depend on the severity of the clinical situation and the judgment and experience of the treating physician.

The oral LD_{50}'s in mice and rats range from 415 to 740 mg/kg and from 560 to 810 mg/kg, respectively. The intravenous LD_{50}'s in these species were 60 and 38 mg/kg, respectively. The oral LD_{50} in dogs is considered to be in excess of 50 mg/kg, while lethality was seen in monkeys at 360 mg/kg. The toxic dose in man is not known but blood levels in excess of 800 ng/ml have not been associated with toxicity.

DOSAGE AND ADMINISTRATION

Exertional Angina Pectoris Due to Atherosclerotic Coronary Artery Disease or Angina Pectoris at Rest Due to Coronary Artery Spasm. Dosage must be adjusted to each patient's needs. Starting with 30 mg four times daily, before meals and at bedtime, dosage should be increased gradually (given in divided doses three or four times daily) at one- to two-day intervals until optimum response is obtained. Although individual patients may respond to any dosage level, the average optimum dosage range appears to be 180 to 240 mg/day. There are no available data concerning dosage requirements in patients with impaired renal or hepatic function. If the drug must be used in such patients, titration should be carried out with particular caution.

Concomitant Use With Other Antianginal Agents:

1. **Sublingual NTG** may be taken as required to abort acute anginal attacks during CARDIZEM therapy.
2. **Prophylactic Nitrate Therapy**—CARDIZEM may be safely coadministered with short- and long-acting nitrates, but there have been no controlled studies to evaluate the antianginal effectiveness of this combination.
3. **Beta-blockers.** (See WARNINGS and PRECAUTIONS.)

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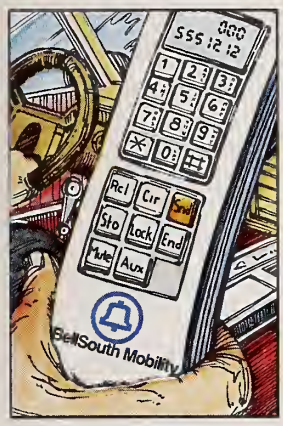
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Hospital Administrator: Jim Eyler

Charter Lake Hospital

3500 Riverside Drive
Macon, Georgia 31209
(912) 474-6200

Beds: 80
Psychiatric Staff: 12
Programs: Adult and Adolescent Psychiatric; Adult and Adolescent Addictive Disease.

For further information about Charter Lake or admission procedures, contact:

Medical Director:
Jack A. Morgenstern, M.D.
Hospital Administrator: Tom McDaniel

Charter Broad Oaks Hospital

5002 Waters Avenue
Savannah, Georgia 31406
(912) 354-3911

Beds: 88
Psychiatric Staff: 16
Programs: Adult and Adolescent Psychiatric

For further information about Charter Broad Oaks or admission procedures, contact:

Medical Director: Henry Brandt, M.D.
Executive Director: Mac Stribling

Charter By-The-Sea Hospital

2927 Demere Road
St. Simons, Georgia 31522
(912) 638-1999

Beds: 60
Psychiatric Staff: 5
Programs: Adult Psychiatric; Adult Addictive Disease
Other Programs: Recovering Nurses; Impaired Athletes; Intervention Services

For further information about Charter By-The-Sea or admission procedures, contact:

Medical Director: Roy F. Thagard, M.D.
Hospital Administrator: James R. Thomas

Charter Brook Hospital

3913 North Peachtree Road
Atlanta, Georgia 30341
(404) 457-8315

Beds: 45
Medical Staff: 9
Programs: Adolescent Addictive Disease

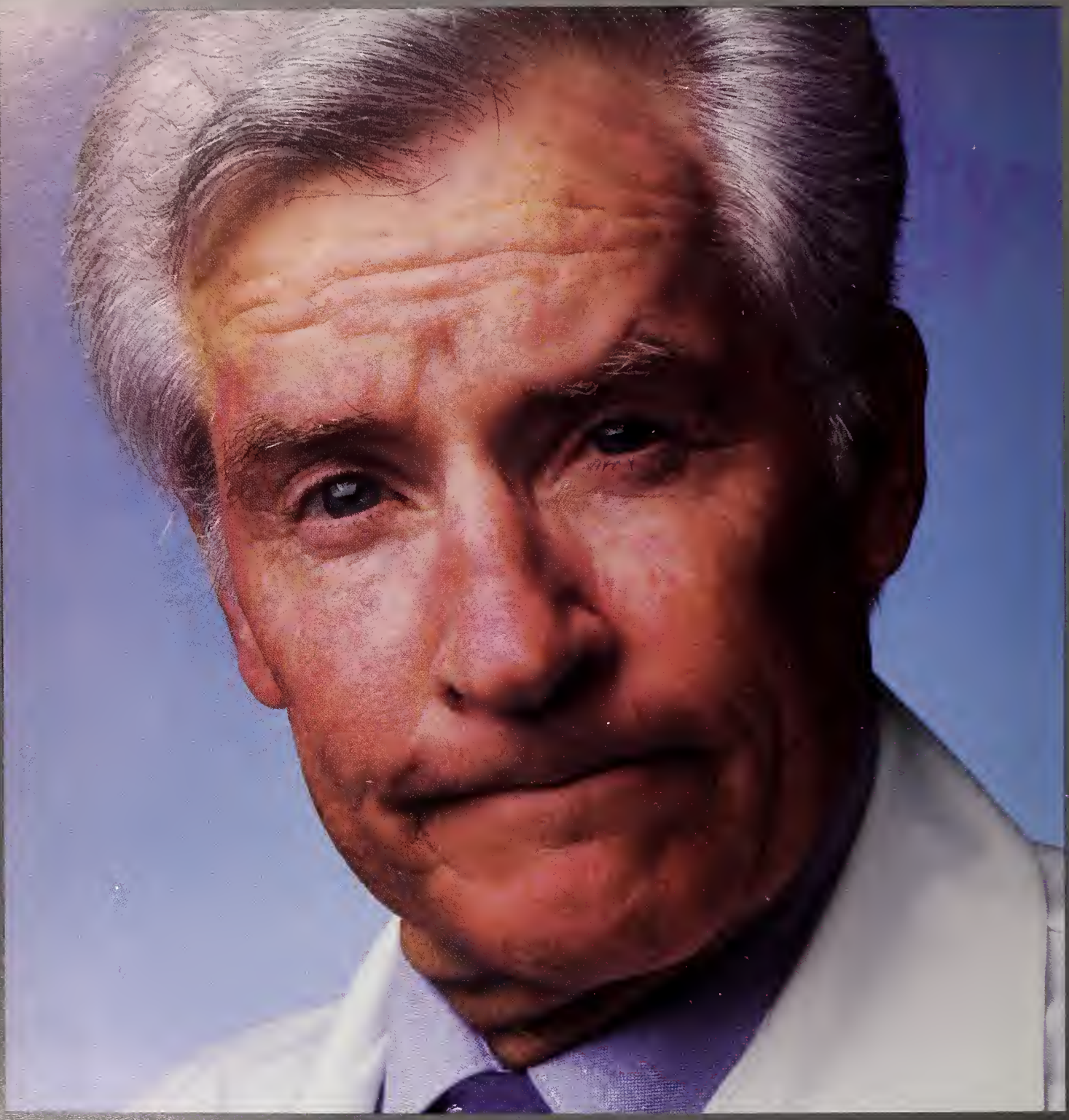
Other Programs: Comprehensive Outpatient Services

Scheduled to open September 1984

For further information about Charter Brook or admission procedures, contact:

Medical Director: Lonny Scarborough, M.D.
Hospital Administrator: Jonathan Farr

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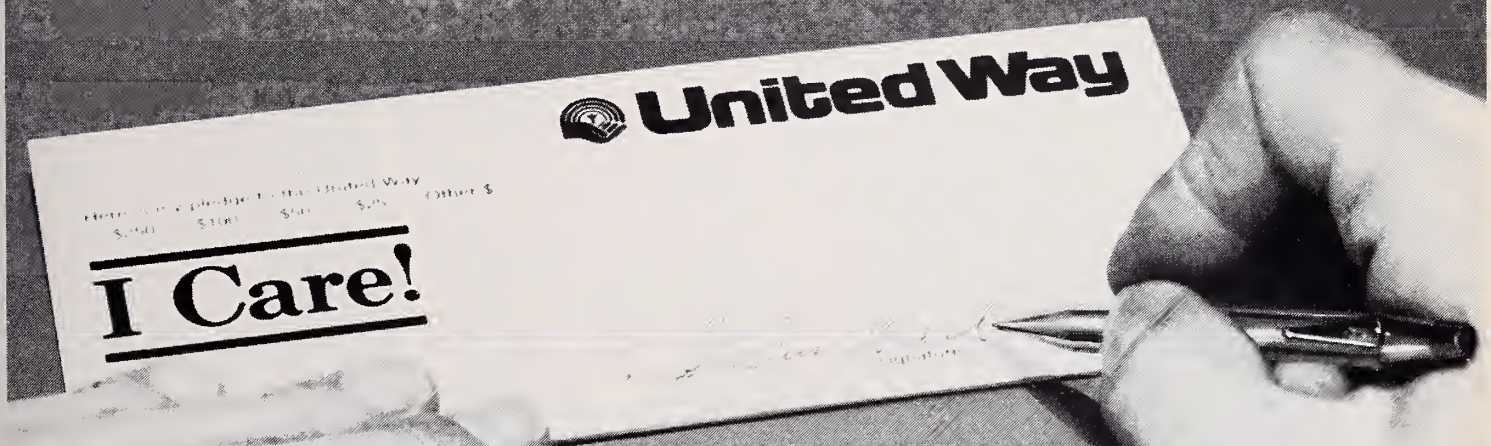
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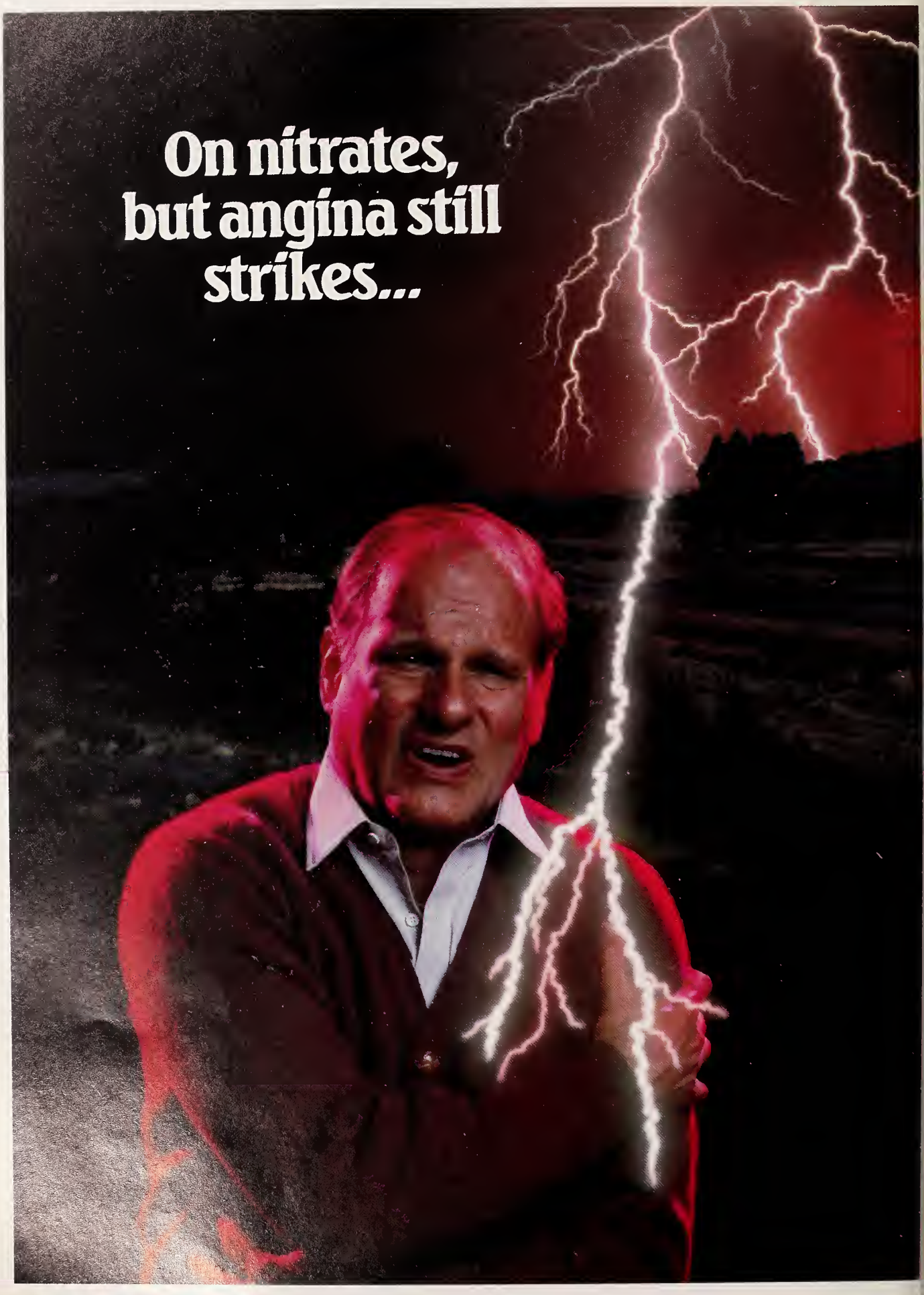
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A public service message from this magazine and the Advertising Council.

This paper discusses aspects of the Supreme Court's recent decision from the hospital's viewpoint. This month's Legal Page discusses the decision as well. Both provide interesting reading.

Withdrawing Life Support: A Sound and Sensitive Opinion by the Georgia Supreme Court

PAUL B. HOFMANN, ***Atlanta****

AT THE TURN OF THE CENTURY, most terminally ill patients in the United States were discharged to the care of their families. By contrast today, it is estimated that 80 percent of deaths occur in hospitals and nursing homes.[1] Outcomes which had been viewed as the province of fate have become matters of human choice. Eight out of the ten leading causes of death in this country for people over 65 are now due to chronic and degenerative diseases.[2] Thus, pneumonia, once called the old man's friend, has, for all practical purposes, died.

It is noteworthy that the Court did not require prior consultation with a hospital ethics committee.

As indicated by the growing number of states which have passed some form of living will legislation, as well as recent court decisions throughout the country, the issue of care for terminally ill patients is receiving increased attention. The extraordinarily rapid growth of technology, and its use to prolong life, has also focused interest on its potential misuse to extend the dying process.

Twenty-five years ago, there were fewer than 1,000 special care beds in the U.S. Today, we have more than 70,000.[3] No place else is the evidence of our medical progress more dramatic. "A Modern Psalm" depicts the ultimate consequence of a technologic imperative which ignores the inevitability of our own mortality.

Medical Science is my shepherd;
I shall not want,
It maketh me to lie down in hospital beds;
It leadeth me beside the marvels of technology.
It restoreth my brain waves;
It maintains me in a persistent vegetative state for its name's sake.
Yea, though I walk through the valley of the shadow of death,
I will find no end to life;
For thou art with me;
Thy respirator and heart machine they sustain me.
Thou preparest intravenous feeding for me
In the presence of irreversible disability;
Thou annointest my head with oil;
My cup runneth on and on and on and on.
Surely coma and unconsciousness shall follow me all the days of my continued breathing;
And I will dwell in the intensive care unit forever.[4]

Written by a Unitarian minister, these sentiments were not intended to be sacrilegious. They capture the genuine fear that many people associate with a loss of control over their own care. When patients are unable to make decisions about the use of diagnostic or therapeutic service, due either to age or

* Mr. Hofmann is Executive Director, Emory University Hospital, 1364 Clifton Rd., NE, Atlanta, GA 30322.

mental incapacity caused by injury or disease, an unambiguous and effective procedure must be available to resolve the dilemma.

Although liability concerns have stimulated, directly or indirectly, more frequent judicial intervention, terminally ill patients and/or their families have routinely decided if and when life support systems should be removed. In two major cases, Judge Hilton Fuller of the DeKalb Superior Court has had a pivotal role in preserving the traditional loci of decision making.

Last year, in *Young v. Emory University d/b/a Emory University Hospital, et al.*, a competent adult patient suffering from amyotrophic lateral sclerosis requested that his respirator be removed, and the court ordered the Defendants to comply.[5] Judge Fuller acknowledged that the complex issues presented by the case involved "civil and criminal law, theology, medicine, medical ethics, social morality and public policy."[6]

Any ruling which recognizes and enhances the patient's right of self-determination, and protects the family, physicians, and hospital . . . is commendable.

In *In re: L.H.R.*, the question was whether and under what procedure life support systems could be removed from an infant who was in a chronic vegetative state with a complete absence of cognitive function. After a hearing conducted by Judge Fuller, the Henrietta Egleston Hospital for Children and the patient's physicians were enjoined from interfering with the constitutional and common law rights of the child and from interfering with the wishes of L.H.R.'s parents and guardian to have life-support systems removed.[7] Of similar and perhaps greater importance, Judge Fuller added the Attorney General as a party to the suit and requested that he prosecute an appeal. This action allowed the Georgia Supreme Court to provide guidelines which would indicate who may make treatment decisions and whether judicial intervention is required. It was Judge Fuller's hope that such guidelines would minimize the need for judicial intervention.[8]

As discussed by Robert Berg in both the April, 1984, and the current issue of this *Journal*,[9, 10] legitimate questions should be raised regarding the number and types of individuals involved in the decision to remove life-support systems. The recent Supreme Court opinion should be well received by both physicians and hospitals because a number of these questions have now been addressed. The Court held that with regard to infant and incompetent adult patients who are terminally ill without hope of recovery and existing in a chronic vegetative state, it is not necessary to obtain a court order to terminate life support if two conditions are met. First, the attending physician and two other physicians with no interest in the outcome of the case must concur in the diagnosis and prognosis. Second, the family or the legal guardian of the incompetent adult or, in the case of minors, the parents of the child, decide that life support should be terminated.

. . . pneumonia, once called the old man's friend, has, for all practical purposes, died.

It is noteworthy that the Court did not require prior consultation with a hospital ethics committee. The use of such a committee was left to the choice of the hospital physician or family. This position is consistent with the guidelines on hospital ethics committees issued by the American Hospital Association (AHA) last March. The AHA suggested that these committees could serve a valuable educational and advisory role, but strongly discouraged their use as decision-making bodies.[11]

Although the Court limited its opinion to "the termination of treatment of the terminally ill patient, adult or child, in a chronic vegetative state for whom there is no reasonable possibility of attaining (or regaining) cognitive function,"[12] the necessity for judicial intervention has clearly been reduced. Any ruling which recognizes and enhances the patient's right of self-determination, and protects the family, physician, and hospital role in promoting this objective, is commendable.

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Proceedings

Special Session — MAG House of Delegates

October 13, 1984

Call to Order

The Special Session of the MAG House of Delegates was called to order by Speaker Jack F. Menendez, M.D., at 9:00 am. Dr. Menendez explained that the purpose of the meeting was to consider a report on alternative medical care delivery.

Special Rule

Under a Special Rule adopted at the beginning of the meeting, the House agreed to defer all motions until after the presentation of the report of the Ad Hoc Committee.

Opening Remarks — S. William Clark, Jr., M.D., President

On behalf of the officers of MAG, I welcome all delegates and other members to this Special Meeting of the House of Delegates. Thank you all for attending this Session on such short notice: MAG's 5600 members are fortunate to have such dedicated delegates to represent them.

As you know, this is a called business meeting to address a single issue. You will consequently find this meeting short on ceremony and socializing. We are here to make a decision, and what we decide will have long-term impacts on all Georgia physicians.

The manner in which medical care is delivered has changed dramatically in the past decade, and the pace of change is quickening. Change is also spreading geographically: patterns once present within Georgia but only in Atlanta are now developing elsewhere. Traditional private practice is still the predominant mode of medical care delivery, but various forms of contract practice are becoming more widespread, affecting thousands of physicians and tens of thousands of patients.

The discussion paper prepared by MAG staff describes the economic situation. The five HMOs in Atlanta (actually encompassing approximately 20 counties around Atlanta) have 140,000 enrollees. All are growing rapidly, and more HMOs will soon be formed in Georgia. We can reasonably expect one-third or so of Georgia's citizens eventually to be served by HMOs.

We cannot be precise in our prediction about PPOs, but we can be sure that the pressures to contain costs will lead employers to seek more discount arrangements, more controls on utilization, and more control over patients' choice of physicians.

The questions facing MAG are very simply expressed: "Does our organization properly have a role to play in this changing economic climate, and, if so, what role will we play?" The questions are easily expressed but not easily answered. Seven optional courses of action have been presented for your consideration, and I understand others may be presented. These options range from maintaining MAG's present activities to embarking on a large and ambitious enterprise similar in magnitude to the formation of MAG Mutual.

We are here to consider these options and to decide among them. If the House decides to maintain the status quo and not involve MAG in the coming changes, so be it. That will be your decision. If the House decides that MAG has a greater role to play, the officers and staff will carry out your wishes.

Whatever you decide, we will be certain that MAG's actions are the result of careful deliberation by its members, and we will not run the risk of reaching a policy by default because we failed to act.

Report of the Ad Hoc Committee on Alternative Delivery Systems

Part I: Options for Action on Alternative Health Plans

This is the text of the report mailed to the delegates which was discussed during the period covered by the Special Rule. The report was presented by a panel consisting of Richard H. Vincent, of Powell, Goldstein, Frazer and Murphy; William Kopit of Epstein, Becker, Borsody, and Green, P.C.; Judith Mattson of Judith Mattson and Associates; and Michael Fowler, Executive Director of the MAG.

The purpose of this discussion paper is to set forth possible courses of action for consideration by the House of Delegates of the Medical Association of Georgia.

The goal of the actions to be considered is to establish a role or policy for MAG which is acceptable to the membership of the Medical Association of Georgia with regard to alternative [medical care] delivery systems and the impact of such systems on the practice of medicine by the physician membership.

* * *

Consideration of the stated options is intended to include the following

facts, situations, issues, and assumptions:

1. The need to consider a policy or role is urgent. Failure to provide leadership and/or guidance to the membership at this time on this critical issue may result in undesirable outcomes.
2. Considerations of third party payment for medical care, which have not been a part of the traditional physician/patient relationship, have now become integrated into that relationship through changes in traditional health insuring programs.
3. Health insuring programs are now combining with health care delivery systems (PPOs, IPAs, and HMOs) — a change which integrates the health care payment and health care provider relationships.
4. Physicians are being asked to consider business and health provider relationships with these alternative health plans and delivery systems (PPOs, IPAs, and HMOs).
5. Changes in the existing style of physician/patient relationship might increase the risk of lapses in quality and continuity of care for the physiologic and psychologic needs of the patients.
6. It is important for each physician in the State of Georgia to examine these issues and decide upon a course of action which is individually appropriate.
7. The Medical Association of Georgia can provide leadership, guidance, and assistance to aid individual physicians in this process.

Prepaid and other alternative delivery systems have become a significant part of Georgia's health care delivery system and will continue to be a significant part in the foreseeable future. For this reason, the MAG House of Delegates is asked to consider MAG's role with regard to various alternative delivery systems in Georgia as well as MAG's role in providing information, advice, and other assistance to its members.

This paper is designed to provide to the members of the House of Delegates: (i) a detailed description of the various options which appear available to MAG at this time, together with an analysis of the relative advantages and disadvantages of each option, and (ii) a concise description of the various forms of delivery and financing systems which are competing with the traditional private practice of medicine, and a discussion of how those systems have penetrated the market in Georgia and the country as a whole.

Specifically, this paper is divided into two parts. In Part I, seven options are presented and discussed, ranging from Option 1, calling for MAG to continue its present activity, through Option 7, calling for MAG to oppose all alternative health plans and focus its marketing efforts on the private practice of medicine. In between, Options 2 through 6 would call for MAG to involve itself, to some extent, in one or more forms of alternative health plans, either through involvement in utilization review, through the formation of an organization of physicians to provide medical services, or through an organization of physicians providing both medical services and health care financing (insurance) services.

Although most members of the House of Delegates will have some working knowledge of the concepts and organizations discussed in the various options, it is critical that each delegate have a thorough understanding of these concepts and options in order for the House of Delegates to reach a well-reasoned and educated decision. Accordingly, Part II of this paper describes the forms of delivery and financing systems which are competing with the traditional practice of medicine — health maintenance organizations (HMOs), independent practice associations (IPAs), and preferred provider organizations (PPOs), as well as combinations thereof (e.g., IPA/HMOs).

Finally, it should be noted that not all of the options discussed in this paper are mutually exclusive. That is, MAG may desire, in certain cases, to approve more than one of the stated options.

* * *

Presented below are the seven options available to MAG at this time. Each option is first described and then followed by a discussion of the relative advantages and disadvantages, on the basis of certain specific criteria:

1. *Level of Antitrust Risk:* The risk that MAG, by taking the contemplated actions, may incur antitrust liability (e.g., treble damages or civil penalties).
2. *Level of Financial Risk:* The extent to which MAG and its members, by taking the contemplated actions, may be at risk if their efforts do not result in a reduction in the cost of providing health care services (i.e., the "insurance" risk).
3. *Expenditure of Resources:* The amount of time, funds, and resources which MAG would expend in taking the contemplated actions (including the time and funds involved in defending against lawsuits and governmental investigations).
4. *Degree of Impact on Health Care Services Market:* The degree to which MAG, by taking the contemplated actions, may have some impact upon the manner in which health care services are delivered in Georgia.
5. *Degree of Impact on Health Care Financing Market:* The degree to which MAG, by taking the contemplated actions, may have some impact on the manner in which health care financing services (i.e., payment mechanisms) are provided in Georgia.
6. *Implementation Time:* The amount of time involved in completing implementation of the contemplated actions.
7. *Fulfillment of Educational Function:* The degree to which MAG, by taking the contemplated actions, would be fulfilling its Constitutional charge to promote the science and art of medicine and the betterment of public health.

* * *

Since a clear understanding of the various alternative delivery systems is essential for the understanding of these options, a discussion of these various forms of delivery systems is provided in Part II of this paper.

Option 1: No Change/Status Quo

MAG's present general association and programmatic activities can be continued with no change to meet new membership needs in this area.

The Association presently maintains minimal activity regarding alternative health plans. Items periodically appear in the *MAG Newsletter,* and occasional all-member mailings are sent on matters of particular importance. Committees have included considerable information on HMOs and PPOs in their annual reports which have appeared in the proceedings issues of the *Journal*. Last June, MAG's attorneys prepared a list of questions physicians should ask about the Blue Cross/Blue Shield of Atlanta VIP program. These questions were sent to all MAG members in the state. Inquiries from individual members have also resulted in occasional research which is not usually included in member communications.

Level of Antitrust Risk: Minimal.

Level of Financial Risk: None.

Expenditure of Resources: Low.

Degree of Impact on Health Care Sevices Market: Minimal.

Degree of Impact on Health Care Financing Market: Minimal.

Implementation Time: Minimal; no need for prior regulatory approval or clearance.

Fulfillment of Educational Function: Relatively low.

Option 2: Improve MAG's Advisory Function

An active program can be started as a clearinghouse in which more effort is devoted to informing MAG members about the development of alternative health plans — both generically and individually and through which direct support is available to both individual members and groups considering alternative health plan affiliation.

The thrust of this option is to deliver more timely and more comprehensive information on alternative health plans to MAG members. Staff would devote considerable effort to developing and maintaining a systematic method of gathering information and would establish a clearinghouse on alternative health plans and delivery systems. Special bulletins and other publications would be sent to members regularly with data and analysis pertaining to IPAs, HMOs, and PPOs. Individual contracts and companies are analyzed under a set of objective criteria. County medical societies and other interested Georgia groups would also be able to tap a speakers bureau.

Level of Antitrust Risk: Relatively low, if implementation is properly structured. If activities are not tightly structured and monitored, antitrust risk increases significantly. Also, there is risk of being sued by persons seeking "deep pocket," although MAG likely would succeed in defending suits if activities were properly structured.

Level of Financial Risk: None.

Expenditure of Resources: Relatively low.

Degree of Impact on Health Care Services Market: Relatively low.

Degree of Impact on Health Care Financing Market: Relatively low.

Implementation Time: Relatively short. (No need for prior regulatory approval/clearance.)

Fulfillment of Educational Function: Relatively high.

Case: California Medical Association (CMA) Department of Contract Evaluation/ Negotiation Services.

CMA established a Department of Contract Evaluation/Negotiation Services in early 1983. Its functions, mostly legal, are to

(1) serve as a clearinghouse of information on contracting for physicians;
(2) disseminate information on contracting to physicians; and
(3) provide objective analysis of physician contracts.

The Department has an annual budget of $150,000 and a professional staff of two — both lawyers. The director reports that 20% of the Department's effort is spent analyzing individual contracts. The Department also publishes brochures and bulletins. The director and his associate spend considerable time on speaking engagements. They have analyzed over 175 contracts in their 18 months of operation. The service is free to CMA members.

Option 3: Promote Physician-Directed Utilization Review for Alternative Health Plans

A utilization management capability created or coordinated by MAG could be made available to contract with PPOs and other organizations.

One of the key objections voiced by physicians against alternative health plans is that they interfere in the physician-patient relationship. By contracting with both the physician and the patient (instead of just the patient), they create a situation in which the physician's contractual obligations to the alternative health plan may appear to conflict with the physician's legal and ethical duty to his patient.

It is widely assumed that utilization management is the principal method by which HMOs and PPOs can contain health care costs. One mechanism for utilization review is already in place in the Georgia Medical Care Foundation (GMCF). MAG could enter into a cooperative venture with GMCF or could create new systems and programs for offering to alternative health plans. This would ensure utilization management systems with input from the physicians of Georgia. In this way, the medical profession retains control over medical matters, although it is clear that a physician-run review agency must be as tough as an insurance carrier's review system.

Level of Antitrust Risk: Depends upon the particular activities undertaken. While the antitrust risk inherent in most peer review activities (e.g., reviewing quality, necessity or appropriateness of health care services) is relatively low, risks increase substantially where activities involve setting or reviewing of fees.

Level of Financial Risk: None.

Expenditure of Resources: Minimal.

Degree of Impact on Health Care Services Market: Peer review can provide the medical profession with some degree of control over medical practice issues — to the extent that MAG's utilization review criteria are utilized by third-party payors. If criteria are, however, set by the third-party payor and simply carried out by MAG physicians, the degree of impact within the health care services market will be minimal.

Degree of Impact on Health Care Financing Market: Relatively low, although the utilization review organization may have substantial input at the formation level of alternative delivery programs.

Implementation Time: Relatively short. (No need for prior regulatory approval/clearance.)

Fulfillment of Educational Function: Relatively high, to the extent that utilization review programs succeed in educating physicians.

Case: The Greater Atlanta Physicians Association Limited (GAPA).

GAPA is a Georgia non-profit corporation whose members are physicians in the 11-county metropolitan Atlanta area. GAPA considered forming a PPO, but (upon legal advice explaining the antitrust risks involved) chose instead to enter into a contractual arrangement to provide utilization review and quality assurance activities for Blue Cross/Blue Shield of Atlanta in the VIP (PPO) program. In addition, GAPA serves in an advisory capacity to Blue Cross/Blue Shield of Atlanta on matters such as credentialing and marketing.

Option 4: Form a Preferred Provider Organization (PPO)

MAG may elect to create a MAG statewide network of preferred providers and arrange contracts between the providers and one or more employers or insurers.

In this option, MAG does not go into the insurance business nor does it, as an entity, provide health care.

Instead, MAG develops a panel of physicians, incorporating utilization review programs and arrangements for insurers. In this way, insurance carriers are able to sell insurance at a lower rate (in part) because of the savings realized through utilization control and negotiated physician fees. The PPO could be open to any MAG member wishing to comply with the contractual requirements. Patients' choice of physician would be limited to the composition of the physician panel, but patients would still be able to see any physician and be covered by their insurance program. Insurance coverage would be at a reduced rate for physicians not in the PPO.

In this option, MAG (probably through a separate entity) would enter the market and compete with other alternative health plans. The physicians of Georgia, through MAG, would be assured of control over the utilization management program for at least part of the statewide health insurance market. There would be an organizational method for channeling information and concerns regarding fees and related matters. Fee-for-service would be retained for physicians who elect to enter into this physician-sponsored arrangement, and patients would retain freedom of choice of physician although benefits may be reduced. Also, physicians would retain the freedom to participate in other alternative health plans as well.

Level of Antitrust Risk: Moderately high. In addition to the obvious price-fixing problems under Section 1 of the Sherman Act, antitrust concerns may be raised as a result of the size and/or composition of the PPO, to the extent that its formation and operation serve to discourage potential entry by other alternative delivery systems, involve exclusionary membership decisions or facilitate collusion among competing physicians.

Level of Financial Risk: Relatively high, most notably in light of the "trade-off" between financial risks and antitrust liability.

Expenditure of Resources: Moderately high.

Degree of Impact on Health Care Services Market: Relatively high. Direct physician involvement and preservation of fee-for-service and patients' freedom of choice.

Degree of Impact on Health Care Financing Market: Relatively high.

Implementation Time: Significant — 3-6 months or more.

Fulfillment of Educational Function: Relatively high.

Case: Although many PPOs are being developed, informal research has disclosed only one operational physician-sponsored PPO in Stanislaus County (California) Foundation.*

Among those being developed is a statewide program in California. PPO, Inc., was formed by California's United Foundations for Medical Care. Each of the 22 Foundations for Medical Care is to develop a separate PPO organization under PPO, Inc.'s, umbrella. The local organization will contract with the individual providers and establish utilization control procedures. PPO, Inc., will do the marketing.

To avoid violation of the Sherman Antitrust Act, PPO, Inc., will not establish the fee structure. That function will be carried out by a separate non-profit corporation known as the Health Care Reimbursement Panel. (It is yet to be determined whether this circumvention will be successful.)

Option 5: Form an Individual Practice Association (IPA)

MAG would create a statewide individual practice association (IPA) — a physician organization which would deliver physician services under contractual arrangements with an HMO or other payment mechanisms.

In this option, MAG would create an organization which would, in turn, enter into contractual relationships with physicians to supply the physician cadre for one or more HMOs. This physician organization might, for example, focus contracting and administrative arrangements in a central operation while retaining strength at the local level through decentralized (perhaps regional) groupings which would conduct peer review and pool financial risk-taking.

Antitrust considerations are less likely in an IPA than in a PPO. While some elements of the insurance risk may accrue to physicians in an IPA, the "risk" (to the physician members and the IPA itself) is the element which lessens the potential for antitrust concerns.

Level of Antitrust Risk: Relatively lower than with regard to the formation of a physician-sponsored PPO. Some of the same antitrust concerns might be raised if the IPA is sufficiently large or gains a substantial proportion of the health care marketplace.

Level of Financial Risk: Relatively high.

Expenditure of Resources: Moderately high, but dependent upon the form of IPA selected and arrangements to serve as the physician services arm of one or more HMOs.

* They may be challenged by the U.S. Department of Justice because of the threat of the organization thwarting the activities of other PPOs, IPAs, and HMOs in the area.

Degree of Impact on Health Care Services Market: Relatively high. Direct physician involvement.

Degree of Impact on Health Care Financing Market: Relatively high, most notably if the IPA can bargain successfully.

Implementation Time: Significant — 3-6 months or more.

Fulfillment of Educational Function: Relatively high for participating physicians.

Option 6: Form an IPA/HMO

Ambitious action would be initiated by MAG similar in magnitude to the formation of the MAG Mutual Insurance Company in 1982. MAG would be creating and spinning off a separate organization.

MAG's IPA/HMO could take any of several forms, but the essence is that MAG, through the new organization, would venture into health insurance and health care delivery. A number of organizational formats are available which would need to be carefully explored in a Business Plan if this direction is selected.

The HMO would administer and market a health benefits package to enrollees and would contract with hospitals and physicians — directly or through one or more IPAs to deliver health services.

Antitrust considerations are less in an IPA/HMO than in other forms of physician-sponsored health plan alternatives. IPA/HMO physician members are not considered competitors; they are involved in a partly integrated economic enterprise, and each is at risk if the IPA/HMO does not succeed.

In this option, MAG would enter the marketplace in an active role. There would be one alternative health plan controlled by the physicians of Georgia, which would compete in the market.

An IPA/HMO has certain additional advantages in serving other markets on favorable terms. The IPA/HMO could seek contracts with Medicare and Medicaid under special programs open only to state-licensed HMOs.

MAG's IPA/HMO would have to have a utilization control system as strict as any other successful HMO. MAG would also have to develop a capital funding mechanism for this alternative. The requirement for capitalization of an IPA/HMO is approximately $3 million, which covers both organizational and operational expenses plus insurance reserves.

Level of Antitrust Risk: Relatively lower than the risks associated with a physician-sponsored PPO. Similar antitrust risks may be raised as a result of the IPA/HMO's size and composition if large numbers of physicians participate.

Level of Financial Risk: Significant business and insurance risks, which would require professional managers.

Expenditure of Resources: Significant. A business plan would be required.

Degree of Impact on Health Care Services Market: Relatively high. Direct physician involvement in both insurance and health care delivery aspects.

Degree of Impact on Health Care Financing Market: Relatively high. Competitive.

Implementation Time: Significant — 6-12 months. Prior approval by the Insurance Commissioner is required.

Fulfillment of Educational Function: Extremely high for participating physicians.

Cases:

1. The San Diego County Foundation for Medical Care founded an IPA/HMO 4 years ago. At that time, Kaiser was expanding in the area, and other closed-panel HMOs were making inroads into the private practice of medicine. Physicians felt threatened.

The HMO is the Greater San Diego Health Plan (GSDHP). The IPA is the San Diego Private Practice Association. After initial financial difficulties brought on by poor management (particularly poor risk management), the IPA/HMO is now successful. It will soon be transformed to a for-profit company and go public.

Even after the stock issue, however, physicians will retain control. Fifty percent of the stock will be owned by individual physicians, and the shares owned by management and others will be held in a non-voting trust.

The present success is due to sound management and a much stricter system of utilization control than was first used. Reserves are adequate, but the stock issue will raise approximately $10 million and assure fiscal soundness even if competition gets keener (as is expected) and if loss experience takes a turn for the worse.

GSDHP uses a gatekeeper system. Every enrollee has a primary care physician — a case manager — and specialist care requires referral by the case manager.

The funds to establish the IPA/HMO were raised by charging an entry fee of $500. Initially, 650 physicians signed up. Now the fee is $1500. The IPA has approximately one-half of the county's 2500 private practice physicians. The HMO has 70,000 enrollees. It is now repaying the federal start-up loan of $1.8 million, a source of capitalization which is no longer available.

2. HealthWays, Inc., a physician-run New Jersey corporation, is virtually a statewide HMO which contracts with county-level IPAs.

The IPA/HMO began in 1977. It was formed by two county medical societies which formed a single HMO and separate IPAs. The HMO now has contracts with six county-level IPAs and expects soon to have contracts with IPAs being formed in the other two counties.

Members of the IPAs are paid on a fee-for-service basis. They are paid at the 90th percentile minus 15% which goes into the IPA's three risk pools. HealthWays has 26,000 enrollees and projects to quadruple in the next 2 years. The HMO has a Medicare contract, and the doctors are paid at the IPA rate which is higher than the Medicare rate.

There are 2500 physicians in the IPAs. The number is expected to grow soon to 3500. (The physician population of New Jersey is 11,000.)

Option 7: Oppose Alternative Health Plans

The MAG House of Delegates may act to recommend a policy of nonparticipation by physicians in alternative health plans.

Many MAG members do not like HMOs and PPOs. Among these members feelings range from the mildly negative attitude to extreme disapproval. A substantial majority of MAG members are in traditional private practice. The charge of the Medical Practice Committee, and hence one of the goals of MAG, is to promote the private practice of medicine. The 1983 and 1984 House of

Delegates directed the Public Relations Committee to undertake a campaign to promote the private practice of medicine to the lay public.

Every alternative delivery system exercises control over a physician's medical practice. Most limit patients' freedom of choice. Every one constrains the physician's ability to set his own fees according to his assessment of his services' worth in the marketplace.

The Association might elect to focus its efforts on the marketing of the private practice of medicine. This effort in marketing would include some institutional advertising but would focus more on helping the individual member market his own practice. A part of this effort would also be to promote the indemnity method of health insurance — reducing third-party payors' control over fees, rather than increasing it.

Level of Antitrust Risk: High.

Level of Financial Risk: None.

Expenditure of Resources: Relatively low, except for costs of defending antitrust actions.

Degree of Impact on Health Care Services Market: Relatively low.

Degree of Impact on Health Care Financing Market: Practically, very little; possible *adverse* impact.

Implementation Time: Relatively short, depends on activity.

Fulfillment of Educational Function: Relatively low.

Option 8: Support and Promote the Private Practice of Medicine.

(Presented by the Medical Association of Atlanta.)

The 1984 House of Delegates of MAG adopted the following definition of the private practice of medicine: *The private practice of medicine is the delivery of medical care, carried out in a direct personal relationship in which direct responsibility for care and payment exists between the patient and physicians.*

The 1984 House of Delegates of MAG adopted the following policy statement: *MAG supports the environment which allows for the freedom of choice for both the patient and physician to select the location of delivery of care, the alternative of treatment, and the method of payment for services rendered.*

It would, therefore, be a conflict of interest for MAG to involve itself in or directly sponsor alternative forms of health care delivery such as: IPA, HMO, PPO; but would not preclude the free choice of its individual physician membership from doing so.

The stated policies of MAG would not preclude MAG from adopting Option No. 2, which would improve MAG's advisory function regarding alternate forms of health care delivery to its physician membership.

The effort to actively promote the private practice of medicine would require reaching out to the public through television, radio, and the print media to present the virtues of the private practice of medicine. Such an endeavor would require potentially large sums of money, i.e., $500,000 to $1,000,000. The funding of this magnitude is not presently available through MAG but alternate forms of fund raising should be considered, i.e., donations from insurance companies, medical supply houses, charitable institutions, voluntary donations from physician membership, and as well grateful patients.

Option 8 would require a dual obligation: (1.) Fund raising and (2.) The expenditure of funds in the active promotion of the private practice of medicine.

Level of Antitrust Risk: Low.

Level of Financial Risk: None.

Expenditure of Resources: Entirely controllable and predictable.

Degree of Impact on Health Care Services Market: Relatively low; increases freedom of choice.

Degree of Impact on Health Care Financing Market: Opens competition.

Implementation Time: Three months.

Fulfillment of Educational Function: High.

Physician Satisfaction: High.

MAG Membership Risk: Very low.

Impact on MAG Staff: Minimal.

SHARE THE COST OF LIVING.
GIVE TO THE AMERICAN CANCER SOCIETY.

Part II — Discussion of Alternative Delivery Systems

The [following] describes the forms of delivery and financing systems which are competing with the traditional private practice of medicine — health maintenance organizations (HMOs), independent practice associations (IPAs), and preferred provider organizations (PPOs). It also describes briefly the extent to which HMOs, IPAs, and PPOs have penetrated the market in Georgia and the country as a whole.

Alternative Delivery Systems

Health Maintenance Organizations (HMOs)

An HMO is a health care plan that delivers comprehensive, coordinated medical services to voluntarily enrolled members on a prepaid basis. It sells, as a package, the services of health insurance and health care. For a prepaid premium, the HMO member receives medical care, hospital care, and related services. The premium does not go up or down according to the quantity of health care he or she consumes. The HMO is at risk, as it is possible that claims will be excessive. Like any other insurance company, therefore, an HMO purchases reinsurance to protect itself against losses.

There are three basic types of HMOs: A *group/staff HMO* delivers services at one or more locations through a group of physicians that contracts with the HMO to provide care or through its own physicians who are employees of the HMO. A *network HMO* contracts with two or more group practices to provide health services. An *independent practice association (IPA)* makes contractual arrangements with individual physicians who treat HMO members out of their own private offices. (The

IPA-model HMO is discussed separately below.)

An HMO has contracts with one or more hospitals in its service area to provide facilities for HMO members needing inpatient care. The rates paid to the hospital are negotiated and are usually less than rates for non-HMO members; however, the hospital is paid on a fee-for-service basis.

HMOs provide health care less expensively than traditional fee-for-service private practice. Savings are realized through control over utilization by the HMO. Such controls include pre-admission certification, concurrent hospital utilization review, and prior authorization for referrals to non-HMO physicians.

In Georgia, HMOs must be licensed by the Insurance Department "to transact . . . the business of insurance." The Georgia Department of Human Resources determines whether or not the HMO has the ability to provide adequate health services. An HMO may also elect to seek federal certification by the Office of HMOs of the Department of Health and Human Services. Federal certification is optional but is usually advantageous to the HMO because it gives "Medicare access" and "employee access."

A federally qualified HMO may contract with the Health Care Financing Administration and enroll Medicare patients (at a rate which is set according to the "Average Adjusted Per Capita Cost" for the HMO's service area). The enrolled Medicare patients are then provided with comprehensive health care for the prepaid premium paid by the government.

Federally qualified HMOs may also approach any employer who has 25 or more employees and who provides health benefits. Such employers *must* offer their employees one group or staff HMO and one IPA-model HMO.

Independent Practice Associations (IPAs)

An IPA is a type of HMO in which health services are delivered by individual physicians, under contract with the IPA, who treat patients in their private offices, along with non-HMO patients. Like other forms of HMOs, IPAs combine both the delivery and financing of care in one system; medical services and insur-

REYE SYNDROME

Reye syndrome is a ***rare but dangerous*** condition that can develop from ***flu or chicken pox.*** It occurs mainly in ***children under 16,*** usually when they ***appear to be recovering.*** Watch for these signs:

- ***Persistent vomiting***
- ***Fatigue***
- ***Confusion and belligerence.***

If your child displays any of these symptoms, ***consult a doctor immediately.***

Some studies indicate that there may be an association between the use of ***aspirin*** for flu and chicken pox and the development of Reye syndrome. Further studies are being conducted on this possibility. In the meantime, the ***U.S. Surgeon General*** suggests that you check with your doctor before using aspirin or any medication when your child has flu or chicken pox.

—A message from the Food and Drug Administration.



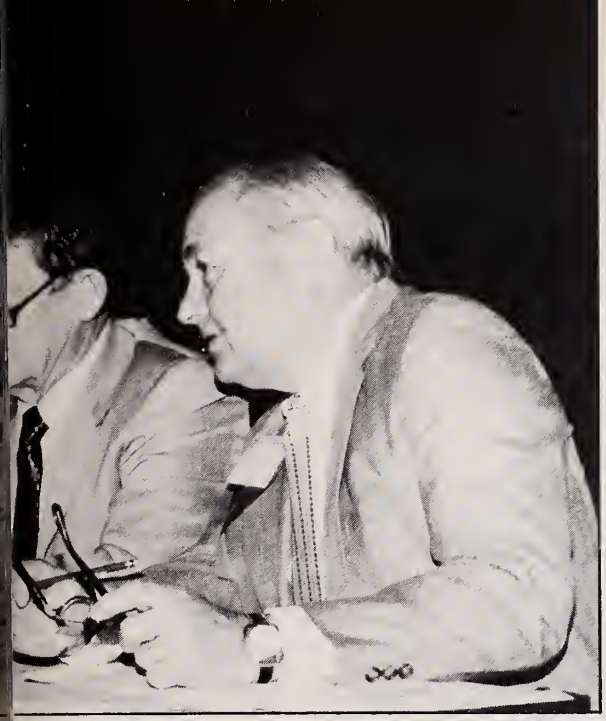



EXIT



















ance coverage are provided by the same organization. In most IPAs, the physicians are paid for their services on a fee basis, though the patient, of course, pays a fixed premium.

An IPA-model HMO may be a dual organization or a single organization. Under the dual plan, there is both an HMO and an IPA, each being a separate corporation and having its own board of directors. The HMO is responsible for finance, marketing, claims, and other aspects of management. The IPA is responsible for utilization review and quality assurance. Medical services are provided for in a series of contracts. The HMO contracts with the IPA (payment on a capitation basis) which in turn contracts with the individual physicians (payment on a fee basis). The HMO also contracts with a hospital and, of course, with the subscribers. Under the unified structure, a single organization acts as both the HMO and the IPA. (It is common for the unified IPA to contract with outside organizations — often insurance companies — for the provisions of essential services — billing, accounting, claims, and even marketing.)

An essential characteristic of an IPA is the risk-sharing by the individual physicians who compose the IPA. The physicians are paid on a negotiated, fee-for-service basis, but a portion of each fee (typically 15% or 20%) is held back and placed in a risk pool to protect the organization against potential losses. The enterprise as a whole must be successful (in a given time period) in order for the individuals to receive their full fee.

Like their counterparts in other kinds of HMOs, the IPA physicians must agree to adhere to the utilization management procedures by which HMOs minimize losses. IPAs, whether dual or unified in structure, are eligible for federal certification, and enjoy the same benefits of Medicare access and employer access. When an IPA physician treats a Medicare patient, he is paid at the IPA rate, which may be higher than the fee Medicare would allow for a patient not covered by an HMO. From the physician's point of view, the IPA is not exclusive in nature; i.e., its membership can include all of the physicians in its service area, provided they are willing to abide by the rules and negotiate a fee schedule acceptable to the IPA.

Preferred Provider Organizations (PPOs)

A recent article in *Medical Economics* described PPOs as "groups of doctors, or doctors and hospitals, working under contract with health insurers. The providers agree to vigorous utilization review and, usually, discounted fees. In return, they're promised bigger patient loads — the insurer's clientele — and considerably faster payment." (8-6-84, p. 60). A PPO is not necessarily a corporate entity like an HMO. It is, instead, a web of contractual relationships. This web may be organized by an insurance company, a group of employers, institutional or professional providers, or others. In most states, there is no state law specifically or explicitly applicable to PPOs. PPOs as such are not licensed or otherwise regulated by the state. Some states' insurance laws effectively prohibit PPOs by forbidding insurers from limiting the insureds' choice among licensed providers. Georgia law contains no such prohibition.

The general characteristics of a PPO are:

—A designated panel of professionals and/or institutions which are "preferred"
—Discounted fees, typically 15% under UCR
—Fee-for-service reimbursement
—No "lock-in" (patients are not bound to use a PPO physician, but there are strong financial incentives for patients to do so)
—No risk-sharing by physicians
—Strong emphasis on utilization review and control
—An effort to pay providers within a designated time.

AMA's *A Physician's Guide to Preferred Provider Organizations* states that, "The administrative and marketing functions of the PPO may variously be performed by the third party administrator, the insurance carrier, the hospital, or the physicians, depending upon how the PPO is organized." (p. 5).

According to AMA's Guide, PPOs are "seen by many as an effective means of combating the competitive influence of alternative delivery systems (such as HMOs)." AMA's survey found that many PPOs have been developed in communities where HMOs have taken a significant market share. (Atlanta's experience is very much in accord with this generalization. Blue Cross/Blue Shield, in explaining its Voluntary Incentive Plan, describes it as being protective of private practice and fee-for-service, helping to preserve these features of medical practice in a market where HMOs are growing considerably.)

HMOs and IPAs are usually considered to be different models of the same contraption, with PPOs being something altogether different. However, the distinction between a PPO and an IPA can become blurred. According to AMA's survey, "Some IPAs are apparently considering the idea of developing additional new business through selective contracting mechanisms [i.e., PPO-type contracts]. They may be in a better position to take advantage of this than group or staff model HMOs, since the IPA model already incorporates elements of the PPO model: the IPA physicians are office-based, they are accustomed to receiving fee-for-service, and their IPA patients often do not constitute a majority of their practice." (p. 6). The same organization, then, could act as both an IPA and a PPO. It could provide medical services to an HMO's enrollees (or its own enrollees if it is unified) on a capitation basis, and at the same time arrange for its members to be the preferred providers of another plan, to be reimbursed on a fee basis for services rendered to the insureds of the preferred provider plan. The distinction between IPAs and PPOs is further blurred now that some PPOs are requiring some risk sharing on the part of physicians.

Market Penetration by HMOs, IPAs, and PPOs

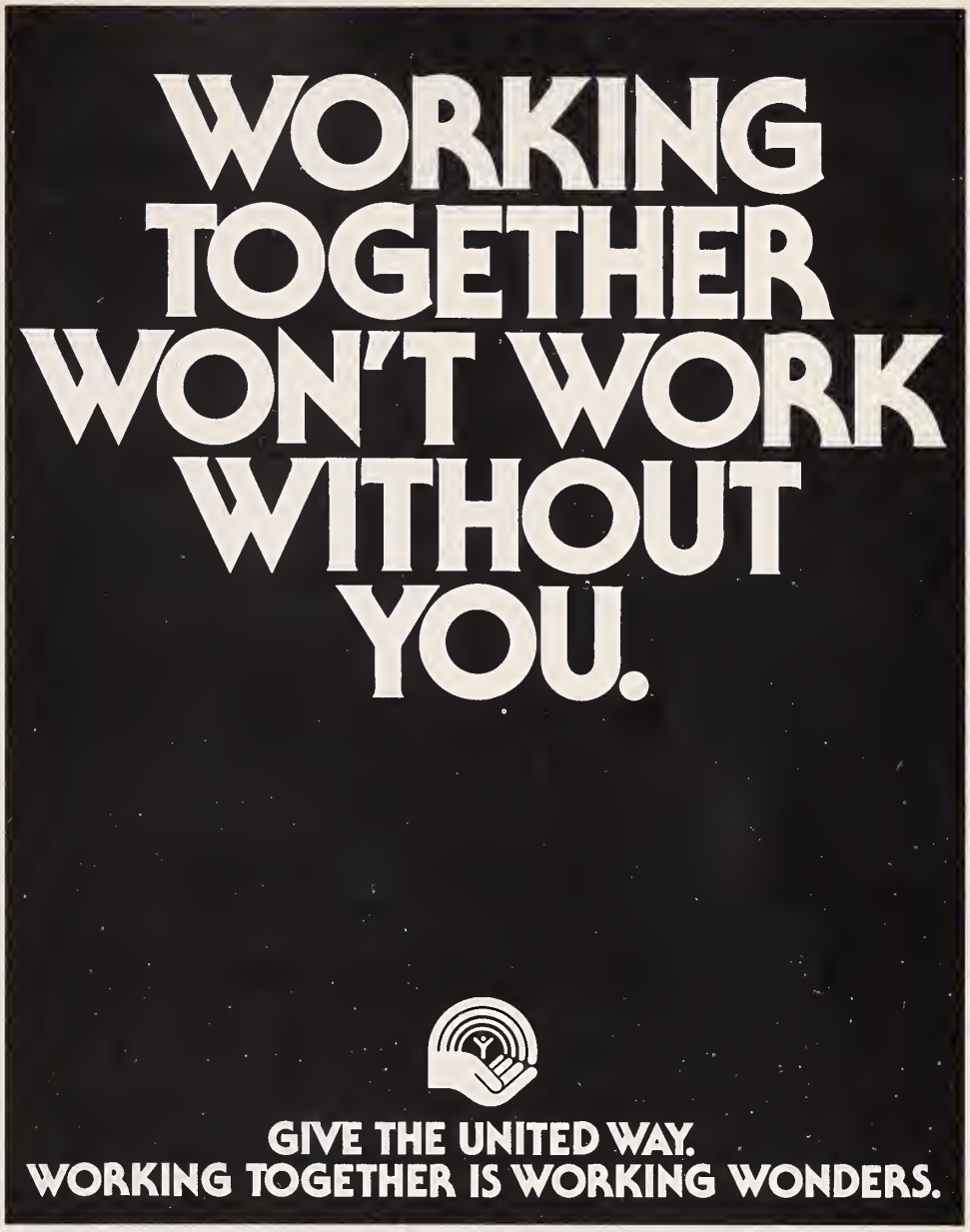
HMOs have been operating in the United States for decades, but the number has increased significantly since federal legislation was passed in 1973 to promote the growth of HMOs. In 1973, there were 70 HMOs with 5,000,000 enrollees. As of April, 1984, there were 326 operational HMOs with a total of

13,600,000 members. The growth rate is dramatic: enrollment increased by 9.2% between November, 1983, and April, 1984. Of the operational HMOs, 136 are IPA-model, 158 are staff or group, and 32 are network. Those which are federally qualified number 169.

There are five HMOs in Georgia, all serving metropolitan Atlanta. All are federally qualified and are therefore able to exploit "employer access" and "Medicare access." Of the five HMOs, two have contracts with Medicare. All have eschewed the employer mandate as an option that hurts more than it helps in marketing. Total enrollment since December, 1983, has grown from 108,200 to 138,800. Predictions are that growth will continue in Atlanta and that expansion will occur in the rest of Georgia. (Humana is planning an HMO in Augusta, and Kaiser is planning expansion into Atlanta.)

The Georgia Insurance Department, which licenses HMOs, has taken the position that the addition of HMOs in Atlanta is "not in the public interest." The public interest is that the existing HMOs remain fiscally sound and, at present, new HMOs would be a threat. State law does not, apparently ("apparently" because the law hasn't been tested) permit the Insurance Commissioner to deny a certificate on these grounds. One may expect only a relatively short delay in the issuance of new certificates, and the presently operating HMOs are making their plans accordingly.

The following chart shows specific information on each HMO.



HMO	Enrollment 12-83	9-84	Medicare	Model	Profit/ NonProfit
Ga. Medical Plan	11,000	21,000	No	IPA	NP
Prucare	26,700	25,200	No	Group	P
AmeriPlan	41,700	50,000	Yes*	IPA	P
Health 1st	8,700	16,000	No	IPA	NP
Health America	20,100	26,600	Yes	Group	NP

* 300 enrollees.

PPOs are less well developed in Georgia and elsewhere than HMOs. Because of their novelty, and because they are not clearly identifiable as are the regulated HMOs, it is not possible to be precise about the extent of their market penetration. AMA's 1983 survey found 104 PPOs in the United States. The survey also found nearly 100 other organizations which were "PPO-type" organizations. In California, the California Medical Association has analyzed 175 PPO contracts which have been offered to California physicians.

In Georgia, the big news is the Atlanta Blues' Voluntary Incentive Plan. Set to become operational on October 1, the VIP has contracted with 17 general hospitals, two psychiatric hospitals, and three outpatient surgery centers which have agreed to average discounts of 10%. Over 1500 of the seven-county area's approximately 4,000 physicians have signed contracts, agreeing to 10% fee discounts and adherence to utilization controls.

Two other PPOs are being formed in Georgia — one in Columbus and one in Macon — but they are not yet operational.

In summary, the medical economic climate in Georgia is still predominately "traditional," i.e., private practice, fee-for-service, noncontractual. However, in the Atlanta area alternative delivery systems are developing rapidly. HMOs are well established and growing, with enrollees increasing by 28% so far in 1984. There is only one PPO, and it is not yet operational, but over half the area's physicians have contracted with the plan.

End of Special Rule

After the presentation of the Report of the Ad Hoc Committee, the House voted by majority vote to end the special rule, opening the floor for motions.

Recommendation of Executive Committee

A motion was made to adopt the following resolution, which was the Recommendation of the Executive Committee.

Resolution from Executive Committee

RESOLVED, that MAG pursue a business plan leading to the formation of a physician organization designed to perform the following functions;

—Assemble one or more groups of physicians (on a statewide, regional, or local basis) committed to providing high quality medical care on a fee-for-service basis — subject to rigorous peer review and utilization management and involving some limited pooling of financial risks and benefits among the individual members of each physician group; and

—Market and, where appropriate, contract for the provision of medical services by any such physician group to appropriate payment mechanisms (e.g., insurance companies, health maintenance organizations, fiscal intermediaries, self-insured employers, etc.) on a basis designed to retain for the group and/or its physician members some portion of the overall health care cost savings effected by the physician members of the group; and

—Encourage the formation of additional physician groups committed to the same principles by providing or arranging for technical assistance, peer review, utilization management and other services as may be appropriate, such as marketing, negotiating, or contracting assistance.

House Action

RESOLVED, that MAG develop a business plan leading to the formation of a physician organization designed to perform the following functions:

—Assemble one or more groups of physicians (on a statewide, regional, or local basis) committed to providing high quality medical care on a fee-for-service basis — subject to rigorous peer review and utilization management and involving some limited pooling of financial risks and benefits among the individual members of each physician group; and

—Market and, where appropriate, contract for provision of medical services by any such physician group to appropriate payment mechanisms (e.g., insurance companies, health maintenance organizations, fiscal intermediaries, self-insured employers, etc.) on a basis designed to retain for the group and/or its physician members some portion of the overall health care cost savings effected by the physician members of the group; and

—Encourage the formation of additional physician groups committed to the same principles by providing or arranging for technical assistance, peer review, utilization management, and other services as may be appropriate, such as marketing, negotiating, or contracting assistance.

Prior to implementation, the plan as developed must be brought back to the next House of Delegates.

Adjournment

There being no further business, the meeting of the House of Delegates was adjourned at 3:00 a.m.

WHY AMA?

The AMA has tackled the issue of cost effective quality medical care by supporting the development of health care coalitions. The Association believes the best mechanism for keeping health costs down without sacrificing quality or accessibility is through voluntary coalitions in which physicians actively participate. Working to promote high quality, affordable medical care in the United States: it's one more good reason why you should be a part of the AMA.

To Join,
Contact your county or state medical society or write: Division of Membership, AMA, 535 North Dearborn Street, Chicago, Illinois 60610 or call collect, (312) 751-6196.

AMA
AMERICAN MEDICAL ASSOCIATION

The most important aspect of the program is providing cost information in the clinical setting at the time of the clinical decision-making process.

Dollars and Sense: Teaching Cost Containment to Medical Students

TERRENCE T. KUSKE, M.D., *Augusta**

WASTE NOT, WANT NOT — An admirable credo, but can it be applied to medical education?

A little over 5 years ago, awareness of the escalating costs of medical care led to recognition of a need for the Medical College of Georgia (MCG) to graduate doctors capable of providing not only high quality patient care but also accomplishing this cost effectively. A review of what was available to teach students about cost containment was discouraging. Though there were a number of concepts, there was no evidence of their practical application. Indeed, the only controlled studies at that time showed that the programs that were developed to introduce cost containment, particularly to housestaff, often had a very negative effect if not very carefully handled.

A preliminary survey of our students, residents, and faculty showed that the vast majority of them did not know the cost of hospital rooms, blood tests, radiologic studies, etc.

In order to address this, a program was developed introducing a number of innovations on the medicine service of the Talmadge Hospital in a controlled setting so as to determine which innovations were effective in reducing costs. The program was presented to Blue Shield of Georgia/Columbus. Their concern for escalating health care costs resulted in their generous and essential support of the project for a 3-year period.

* Dr. Kuske is Professor of Medicine, Associate Dean for Curriculum, School of Medicine, Medical College of Georgia, Augusta, GA 30912.

Design of the Program

The program sponsored by Blue Shield of Georgia/Columbus consisted of four parts. The first of these was the development of computer-based patient simulations by Dr. Abdulla Abdulla of the MCG faculty. These sophisticated simulations allowed the student to work up a patient at a microcomputer, complete with history and physical, and attempt various medical interventions with resultant improvement or worsening of the patient's condition. The simulations have been continually improved and now incorporate laser video technology. The cost of each step in the workup is tallied with feedback to the student on whether the cost of the evaluation was appropriate and whether unnecessary studies and tests were ordered. These programs have been presented at meetings of the American Heart Association, the American Association of Medical Colleges, and a number of other national and regional organizations. Many of our houseofficers and students have completed these programs and found them to be a new and rewarding educational experience.

The second part was the implementation of biweekly cost containment conferences. Faculty members trained in decision analysis are now using these newer techniques of scientifically determining the outcomes of therapeutic approaches and incorporating them in our conferences within the Department of Medicine. In addition, the emphasis on cost containment has led to elements of cost awareness in all of our conferences.

The third and fourth parts of this program together comprised the controlled study. The question posed by the study was, "Does better awareness of cost

lead to better decisions in cost-effective management of the patient?'' A preliminary survey of our students, residents, and faculty showed that the vast majority of them did not know the cost of hospital rooms, blood tests, radiologic studies, etc. The project was designed to provide cost information, in a non-confronting way, on a regular basis to our services. This was done in a controlled fashion, in order to see what increased knowledge of costs would do to the use of common tests. A computer-based laboratory reporting system was developed which reported not only the results of the test but also its cost and the cumulative charges on that patient for laboratory data to date.

It appears from this study that if cost information is provided on a regular basis to the young physician, it will reduce the use of services.

In addition, daily cumulative bills were developed on all patients on the medical services. At 3 A.M., the hospital mainframe computer generates bills consisting of all charges accumulated on the patients as of midnight, which are then posted on the front of the patients' charts. While the usual hospital bill is very complicated, these bills include only general categories of charges for simplicity and readability. They are grouped into room charge, pharmacy, radiology, clinical laboratory, and supplies categories. Over the next year, this information was alternately provided to half of the medical services, retaining the others as controls, in a crossover design. The impact of this was assessed in the care of over 1,000 patients on the medical services at Talmadge Hospital.

Results of the Study

There was a significant decline in the use of laboratory tests in the groups receiving cost information ($p = < .01$). Additionally, there was a significant ($p = < .01$) decline in the total costs of laboratory tests for patients on services receiving cost information. One of the surprises was that the radiology charges also declined significantly ($p = < .05$) in those services receiving regular cost information. One of the areas of most interest was whether this study would show a decrease in the mean patient stay in the hospital. Though it did decline, it did so on both study and control services, and the half-day greater decline in the services receiving cost information was not statistically significant. We feel very strongly encouraged by this, however, and feel that reduction in length of hospitalization is the most important goal in our education of students and houseofficers in cost-efficient care of patients.

As with any such project, some mistakes were made. To bring the cost of common laboratory tests to the attention of houseofficers and students, a grocery store type sign was developed labelled, ''This Week's Special,'' with a space for costs of various tests. They were placed in the service offices, and different tests with their cost were posted every 5 days through the period of study. Unfortunately, the use of the tests increased, leading to the suspicion that the housestaff actually believed they were ''on sale.'' This particular component of our cost containment project has been discontinued.

It appears from this study that if cost information is provided on a regular basis to the young physician, it will reduce the use of services. To be effective, the information must be current and available at the time decisions are made. While this is demonstrably the case for the clinical laboratory and radiology, the most central issue is the need for decrease in mean patient stay in the hospital, particularly in relation to diagnosis-related group (DRG) reimbursement. The very encouraging information from this study led to extension of the information to all of the medicine services.

At 3 A.M., the hospital computer generates bills consisting of all charges accumulated on the patients as of midnight, which are then posted on the front of the patients' charts.

As a tertiary care referral center, a large number of patients in the MCG hospitals, particularly in the medicine services, have end-stage disease and/or multiple organ system failure. With these very complicated cases, efficient and rapid workup of patients is very difficult. Nonetheless, while in the 1970s we had a mean patient stay of about 15 days per patient, by the end of the study it had decreased to 10 days and is currently down to 8.5 days, with no change in the type of patient population. The faculty and staff have dramatically improved the efficiency of provision of medical care in the MCG hospitals.

Present Status and Future Directions

Future plans include a number of new programs. Mandatory conferences on DRG reimbursement systems have been instituted for the faculty and the housestaff and have been opened to students as well. On the medicine services, the Chairman reviews all cases in the hospital for longer than 14 days with the housestaff to see whether there are problems relating to provision of ancillary services in the hospital which are delaying the workup of the patient. In-house DRG costs are being compiled in order to

assess the efficiency of patient workups. The cost containment conferences are being continued, along with that emphasis on and enthusiasm for efficient care that has developed among the faculty and the housestaff.

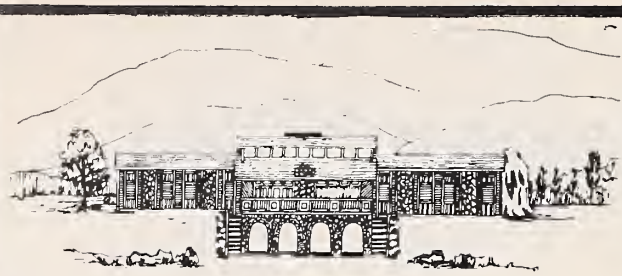
Further plans include the extension of the daily bills to the remainder of the services in the hospital. The DRG amount will be determined and placed on the front of the chart along with the bill, so the housestaff can see daily how close they are to accomplishing the workup within the expenditure allowed to the hospital.

There was a significant decline in the use of laboratory tests in the groups [of students] receiving cost information ($p = < .01$).

The target audience of this program has been exclusively at the clinical level, the junior medical students, and houseofficers in the Talmadge Hospital on the medicine services. Approximately 60% of the resident staff rotates through the medicine services, and, therefore, are exposed to it. All of the medical students rotate through the medicine services, and thus have had at least some exposure to this program during this rotation. As this is extended to other services, greater emphasis should be gained throughout the hospital. The most important aspect of the program is providing the cost information in the clinical setting at the time of the clinical decision-making process. Emphasis must be placed on the role model of the attending physician as an astute clinician who provides not only for his/her patient's optimal care but also for the efficient and cost-effective evaluation and treatment of that patient.

The project was designed to provide cost information . . . on a regular basis . . . in order to see what increased knowledge of costs would do to the use of common tests.

The MCG faculty has an increased level of interest in and awareness of these needs. Approximately 60% of the patients are covered by Medicare and Medicaid, and survival of the hospital depends on how well the faculty responds to this new challenge. It has become a sort of game among the housestaff to see who can do it best — how to get it done more efficiently. In this kind of setting, a team effort develops with the input of the students and the housestaff who identify the problems for the attendings, who then use their influence to resolve them, in order to provide more efficient services within the hospital.



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editorial
editorial
editorial

Alternatives Considered by the Special House

On October 13, 1984, the MAG House of Delegates grappled with the problem of alternative health care delivery systems in Georgia.

The "options" put before the delegates ranged from rejection of alternative health care delivery systems out of hand, to formation of an I.P.A. by MAG, to re-affirmation of private practice, complete with a public relations campaign.

As I chaired the meeting, I sensed in the delegates a need to deal with the problem of alternative delivery systems, and, at the same time, no clear consensus existed as to which was the correct course of action to take. Some of the delegates stated that they did not feel they had enough information to act definitively on the formation on an I.P.A.

After further discussion, including the presentation of an option to reaffirm private practice as the best health care delivery system, the delegates voted to continue studying the formation by MAG of an I.P.A., with definitive action to be taken at the 1985 Annual Session.

The discussion lasted several hours and showed, once again, the ability of the delegates to take on tough problems, consider them fully, and act.

As we have with PSRO, MAG Mutual, and many other important issues, I have full confidence that the House of Delegates will deal with this issue — that of alternative health care delivery systems — at the next Annual Session.

Jack F. Menendez, M.D.
Speaker of the House



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Removing Life Support: A Constitutional Right

ROBERT N. BERG, *Atlanta**

In the April, 1984, Legal Page, we raised the question of whether or not physicians, hospitals, parents, guardians, attorneys, clergymen, review committees, government representatives, and the courts were all necessary parties in the decision to remove life-support systems from a terminally ill infant.[1] This question arose as a result of an order, issued by Judge Hilton Fuller of the DeKalb Superior Court, that a 4-month-old, severely brain-damaged infant be taken off a respirator.[2] Prior to the issuance of the order, however, all of the persons and entities described above in fact *were* involved, to some degree, in the decision-making process.

Hospital ethics committee review and judicial intervention need not be involved in the determination to remove life-support systems from a terminally ill incompetent patient.

Judge Fuller recognized the inherent unfairness, in terms of the emotional strain and financial expenditures involved, in a process whereby the persons and institutions responsible for the care and treatment of patients were *routinely* required to involve outside sources — review committees, law enforcement officials, the courts — before making and carrying out right-to-die decisions. He also recognized that, without some guidance from the Georgia appellate courts, parents, physicians, and hospitals would continue to pursue the involvement of these outside sources, so as to minimize their possible exposure to civil or criminal liability. Accordingly, Judge Fuller took the extraordinary step of adding the Attorney General of the State of Georgia as a party to the proceeding and requesting that he appeal Judge Fuller's order so that the Georgia appellate courts might have an opportunity to provide much needed guidance. The Attorney General did so, and the Georgia Supreme Court, on October 16, 1984, unanimously affirmed Judge Fuller's decision.[3]

The Constitutional Right to Terminate Treatment

The Supreme Court commenced its analysis by acknowledging that, "(i)n Georgia, as elsewhere, a competent adult patient has the right to refuse medical treatment in the absence of conflicting state interest."[4] From this, the Court found that the right to refuse *or terminate* medical treatment "rises to the level of a

* Prepared at the request of the Medical Association of Georgia. Mr. Berg is a partner in the firm of Powell, Goldstein, Frazer & Murphy, General Counsel to the Association, 1100 C & S National Bank Building, Atlanta, GA 30335.

constitutional right which is not lost because of the incompetence or youth of the patient.''[5] In other words, the Court found that *every person,* whether a competent adult or an incompetent infant, has a constitutional right to refuse the initiation or continuation of medical treatment, a right which may be exercised in the absence of some significant overriding state interest.

In the Court's view, no such compelling state interest was present in the *L.H.R.* case. Rather, the Court found that the state interests normally attendant in right-to-die decisions — e.g., the interest in maintaining life and preventing suicide — did not exist in the situation involving a terminally ill infant:

> Once the diagnosis is made that the infant is terminally ill with no hope of recovery and in a chronic vegetative state with no reasonable possibility of attaining cognitive function, the state has no compelling interest in maintaining life. The decision to forego or terminate life support measures is, at this point, simply a decision that the dying process will not be artificially extended. While the state has an interest in the prolongation of life, the state has no interest in the prolongation of dying, and although there is a moral and ethical decision to be made to end the process, that decision can be made only by the surrogate of the infant.[6]

The Parents' Role in the Decision-Making Process

As a practical matter, of course, there is a significant difference between a competent adult, who can independently exercise his or her right to refuse medical treatment and express the intention to do so, and an incompetent infant, who can do neither. The Court dealt with this distinction by holding that ''the right to refuse treatment or indeed to terminate treatment may be exercised by the parents or legal guardian of the infant after diagnosis that the infant is terminally ill with no hope of recovery and that the infant exists in a chronic vegetative state with no reasonable possibility of attaining cognitive function.''[7] Thus, it is the parents or legal guardian of the terminally ill infant who are primarily responsible for exercising the infant's right to remove or terminate life-support systems.

The Physicians' Role in the Decision-Making Process

The Court also placed physicians in a major role in the decision-making process with regard to the removal of life-support systems from a terminally ill infant. Essentially, the Court held that, before any removal decision may be made and implemented, a critical *medical* decision must be made — the infant must be diagnosed as being terminally ill with no hope of recovery and existing in a chronic vegetative state with no reasonable possibility of attaining cognitive function. The Court reasoned that this diagnosis and prognosis ''must be made by the attending physician.''[8] In addition, the Court required that ''(t)wo physicians with no interest in the outcome of the case must concur in the diagnosis and prognosis.''[9]

Thus, the Court found that right-to-die decisions may be made in the context of the traditional physician/patient relationship (including, in the case of infants or incompetents, the parents or legal guardians of the patient), without any necessary involvement of outside sources.[10] Specifically, the Court expressly found that hospital ethics committees need not be consulted prior to making and implementing the removal decision, although the Court recognized that such committees could be used in appropriate circumstances, such as upon the request of the hospital, physician, or family.

In addition, the Court found that judicial intervention need not occur in every

case. "While the courts are always available to protect the rights of the individual, the condition of this individual is such that the decision is one to be made by the family and the medical community."[11]

It should be noted that the Court's opinion is quite narrow in scope, dealing only with the situations where a terminally ill infant or terminally ill incompetent adult patient (who, in the Court's view, stood in the same legal posture as a terminally ill infant),[12] in a chronic vegetative state with no reasonable possibility of regaining cognitive function, seeks, through his or her parents or legal guardian, to terminate life-support systems. At several places in the opinion, the Court limited its holding to these cases, stating for example, that:

> We do not consider here the issue of initiation of treatment rather than its termination, the initiation or cessation of treatment for a terminally ill but cognitive child or adult, or any of the other numerous issues which could arise and will no doubt arise in connection with the treatment of hopelessly and terminally ill patients.[13]

Potential Physician Liability in Connection With Right-to-Die Decisions

As noted above, the primary reason why physicians, hospitals, and parents sought to obtain hospital ethics committee review and judicial intervention in the decision-making process — before the Supreme Court's opinion in the *L.H.R.* case — was the potential civil or criminal liability which might arise out of the decision to remove life-support systems in the absence of a court order. The Supreme Court's opinion does not specifically treat this liability issue. Nonetheless, we interpret the Court's opinion as meaning that the liability for physicians arising out of their involvement in the decision-making process with regard to the removal of life-support systems from a terminally ill infant or incompetent adult will be the same as the physician's liability in other areas of medical practice. That is, if the attending and two independent physicians correctly diagnose the patient's condition as "terminally ill with no hope of recovery and that the infant exists in a chronic vegetative state with no reasonable possibility of attaining cognitive function," those physicians should not incur any civil or criminal liability as a result of the subsequent removal of the life-support systems. On the other hand, if the physicians negligently diagnose the patient's condition, those physicians may be liable for the results of their negligence.

Notes

1. Berg, R. N. An infant's right to die: Must physicians, hospitals, parents, guardians, attorneys, clergymen, review committees, government representatives *and the courts* be involved in the determination? JMAG, Vol. 73 (April, 1984).
2. *In re L.H.R.*, Civil Action No. 84-1757-5, DeKalb County Superior Court (February 10, 1984).
3. *In re L.H.R.*, Case No. 41065, ___ Ga. ___ (October 16, 1984).
4. *Id.*, slip op. at 11.
5. *Id.*
6. *Id.*, slip op. at 12.
7. *Id.*, slip op. at 11-12.
8. *Id.*, slip op. at 12.
9. *Id.*
10. The Medical Association of Georgia, alone among the parties and amicus curiae submitting briefs to the Court, contended that right to die decisions involving terminally ill infants should be made by the parents or legal guardian, with the help of the physicians involved, without the mandatory involvement of any outside sources. It appears that the Court found MAG's analysis to be quite persuasive.
11. *Id.*
12. *Id.*, slip op. at 13.
13. *Id.*, slip op. at 10.

(Editor's note: Read Mr. Paul Hoffman's article on pages 825-826 which deals with the same subject from the hospital's viewpoint.)

cancer page
cancer page
cancer page

Helping Patients Cope: The Role of the Patient Visitor in Cancer Care

SUSAN S. CONNELLY, M.S.W., A.C.S.W., *Atlanta**

ADVANCES IN MEDICAL SCIENCE allow many cancer patients to live longer and more normal lives. Simultaneously, American culture is oriented toward youth and fitness. Given this climate, there are few role models for cancer patients or their families. "Veteran" cancer patients, however, can be effective in coaching fellow new patients to deal with the practical and interpersonal aspects of this disease.

Supportive contact between veteran and newly diagnosed patients is not a new mode of coping. Patients naturally chat in clinic waiting rooms and hospital hallways. Relatively recently, these natural social resources have become formal support systems under the auspices of volunteer organizations and medical institutions. Visitation programs for ostomy, laryngectomy, and mastectomy patients are currently sanctioned by the American Cancer Society (ACS), and a non-site specific peer visitation service is being developed nationally by ACS. Physician referral is a hallmark of these visitation programs.

While not constituting a panacea for the crises created by cancer's diagnosis or treatment, the trained patient visitor may help prevent secondary emotional and interpersonal problems.

A patient visitor is defined as a medically stabilized, successfully adjusted cancer patient or family member who donates time to meet with others to share his experiences. These trained volunteers serve as resources for prevention of subsequent medical illness or emotional problems brought on by the stress of having cancer. This concept is based on a non-medical model. Patient visitors relate to the person behind the diagnosis, thereby decreasing the loneliness and alienation felt by many cancer patients. Adaptive success toward normalcy is the goal, manifested by the patient and family regaining a sense of mastery and making a dignified adjustment to a difficult life situation.

Patient visitors may act in a variety of roles, depending on the guidelines of the specific program. The patient visitor epitomizes the process of transition to an afflicted but adjusted person, thus providing "living proof" of functional adaptation to cancer, its treatment and an altered body image. Through "experiential

Continued on p. 848

* Ms. Connelly is Clinical Social Worker and Oncology Counselor, Health Psychology Center, Northside Hospital, 1000 Johnson Ferry Rd., Atlanta, GA 30042.

Prepared at the request of the Georgia Division, American Cancer Society. Others wishing to contribute papers to this Page are invited to send them to T. Gray Fountain, MD, Cancer Page Editor, 910 N. Jefferson, Albany, GA 31708.



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Cancer Page — Continued from p. 846

empathy,'' the veteran coaches the new patient to focus on attainable goals and realistic expectations, giving direction, new value, and hope. Likewise, by becoming a ''surrogate patient'' for the patient's family, the volunteer visitor can facilitate more candid communication about sensitive or difficult topics.

Trained patient visitors also act as tutors through sharing their ''experiential knowledge.'' This allows patients to mentally rehearse upcoming treatment events and reduces anticipatory anxiety. In some programs, the visitor is equipped with a ''kit'' containing educational literature, demonstration materials, or prostheses. At times, there is a fine line between providing practical information and discussing the patients' treatment, diagnosis, or prognosis. Physicians and health care professionals rightfully disapprove of patient visitors encroaching on this medical territory. However, the well-trained and supervised volunteer can be effective in linking the medical prescription to the specifics of the social milieu within which the patient must function. Research indicates that contact with a volunteer visitor can enhance conscientious consumerism, intelligent decision-making, and compliance with proven treatment regimens.

''Veteran'' cancer patients coach fellow new patients to deal with the practical and interpersonal aspects of this disease.

What factors promote a successful cancer patient visitor program? From the outset, it is important that program guidelines specifically define the locus of responsibility of volunteers. Programs which have a history of success, for example, Reach to Recovery, the laryngectomy and ostomy visitation programs, have set clear, achievable goals for their visitors. Other factors which contribute to the success of patient visitor programs are careful recruitment and screening procedures. Having been successfully treated for cancer is not a sufficient qualification for effective patient visiting. Prospective visitors must be screened for such factors as communication skills and ability to empathize, as well as a willingness to abide by the stated limitations of the program.

Descriptive research indicates that program guidelines should also include a training period, ongoing supervision, and standards for recertification of visitor credentials. To be broadly accepted and utilized by the medical community, visitor programs need to build in accountability and a reasonable assurance that the volunteer will utilize supervision and/or direct professional intervention when necessary. Instituting these guidelines protects the visitors from burnout and reduces the danger of volunteers developing the false self-assurance that they are equipped to do in-depth counseling. The key to a good training program is not the quantity of knowledge imparted to prospective visitors, but the specificity of that knowledge and clear indications of the limits of its applicability.

While not constituting a panacea for the crises created by cancer's diagnosis or treatment, the trained patient visitor may help prevent secondary emotional and interpersonal problems. Patient visitor services appear to be an effective adjunct to professional intervention in comprehensive cancer treatment.

Aspects of Coronary Heart Disease in Blacks

LAURENCE O. WATKINS, M.D., *Augusta**

In March, 1983, the American Heart Association Council on Epidemiology sponsored, as part of its 24th Annual Conference, a symposium on Coronary Heart Disease in Black Populations. At this conference, investigators presented results obtained when many data bases were analyzed from the point of view of race. In September, 1983, the National Heart, Lung, and Blood Institute sponsored a Working Conference on Coronary Heart Disease in Black Populations which was attended by a multidisciplinary group of research scientists and community health experts with concerns or experience relevant to the scientific study of coronary heart disease (CHD) in American blacks. The proceedings of the symposium and of the Working Conference were published in a supplement to the *American Heart Journal* in September, 1984. It is not possible in a brief article to provide an adequate summary of these papers, but some of the highlights will be reviewed.

Gillum[1] presented analyses of national vital statistics which indicate that CHD is the leading cause of death among US blacks and that the mortality rates among blacks are similar to those of US whites. This is a controversial observation, since many clinicians do not consider it to be in accord with their experience. Since vital statistics may have many deficiencies,[2] it is of interest that at least three sets of observations in the last 20 years are in some accord with Gillum's conclusion. Garfinkel[3] reported that in a study initiated in 1959 by the American Cancer Society involving 12-year follow-up of more than 1 million Americans, black men had a CHD mortality rate 78% of that of white men, while black women had a rate 107% of that of white women. Neaton et al[4] observed that among the 361,662 men aged 35-57 years from 18 US cities who underwent screening in 1973-1975 for the Multiple Risk Factor Intervention Trial (MRFIT), the black group (6.5% of the total) had a CHD mortality rate over the ensuing 5 years which was 88% of that of the white group. Of special interest to Georgians is the observation over 20 years of follow-up (1960-1980) in Evans County that CHD mortality in black men aged 40-64 years was 86% of that of white men.[5]

All of these data have qualitative deficiencies, but they are sufficient to dispel what Gillum describes as the "myth" of black immunity to CHD![1] To some degree, the initial Evans County observations contributed to the persistence of this "myth," though it should be noted that Cassel, even as he commented that "white sharecroppers and all black men are virtually immune to CHD," expressed reservations about the generality of these findings to the US population.[6]

The Working Conference participants concluded that the currently available data do not allow definitive assessment of the relationship of the standard risk factors to

* Articles for this Page are sponsored and approved by the American Heart Association, Georgia Affiliate. Those wishing to contribute papers are invited to send them to Laurence O. Watkins, M.D., "Heart Page" Editor, Section of Cardiology, Dept. of Medicine, MCG, Augusta, GA 30909.

coronary artery disease in US blacks, because the studies have not included sufficiently large numbers of black subjects.[7] Examination of risk factor trends among blacks in the National Health and Nutrition Examination Surveys of 1971 and 1980 indicate a decreased prevalence of untreated hypertension during this period, a significant decrease in the prevalence of smoking among black women, and little change in the prevalence of elevated serum cholesterol.[8] This reduction in risk factor levels may explain part of the decline in the observed CHD mortality in blacks. From the point of view of physician intervention on risk factors, it is significant that among the Special Intervention cohort of MRFIT, smoking cessation rates, dietary and lipid changes, and degrees of response to stepped-care antihypertensive therapy were similar in blacks and whites.[9]

Biologic differences between racial groups have been suggested as explanations for observed patterns of CHD incidence. It has been suggested that the incidence of CHD in blacks should be even higher than in whites in view of the excess prevalence of hypertension, and that some protective factor(s) might account for the lower than expected incidence. High-density lipoprotein cholesterol (HDL-C) levels, which are higher in blacks, has been suggested as a possible explanatory variable.[10, 11] Though some investigators have speculated that these differences have a genetic basis,[11] others have questioned the assumption that race designates important genetic factors in the population and have pointed to the social origin of racial categories.[12]

The importance of socioeconomic factors for morbidity and mortality in US blacks was emphasized in many of the discussions.[13-15] Social class appears to be a determinant of CHD risk. Keil et al[16] reported from Charleston, South Carolina, a lower incidence of CHD in blacks of high social class, compared to those of low social class, an observation similar to that made among Evans County whites.[5] It is possible that differences in socioeconomic status underlie some black-white differences in patterns of diagnostic evaluation and clinical decisions with regard to therapy. Data from a tertiary referral center in Birmingham, Alabama,[17] show a 24:1 white-black ratio in patients who underwent coronary arteriography in 1970-1978, though the patient population was about one-third non-white. In addition, a much lower proportion of black patients (16%) was initially referred for coronary bypass surgery than whites (43%). Even when account was taken of greater vessel involvement in the white group, race remained a significant predictor of the choice of surgical therapy.

The NHLBI Working Conference sought to identify research needs concerning CHD in US blacks, and a subsequent NHLBI conference in February, 1984, sought to identify strategies for prevention of CHD in blacks. In view of the high black CHD mortality rate, this two-pronged approach, which involves clarifying the impact of biologic and sociocultural factors on CHD in blacks and intervening to diminish morbidity and mortality, is clearly required. Practitioners will find much to stimulate reflection and action in the *American Heart Journal* supplement, which is being distributed widely, as a service to the profession, by the Schering Corporation.

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president's letter



Medicine and Politics: The Twain Hath Met

THEY MET at the MAG Legislative Seminar the last weekend of August! A total of 112 MD participants, representing 24 specialties, and 10 legislators, state and national, attended this seminar designed to teach Georgia physicians about the legislative process. We are grateful for the legislators who served as our faculty.

The one common theme expressed loudly and clearly by each legislator was that the *Legislature* will be deciding the fate of medical issues, medical finances, and medical practitioners — more in 1985 than ever before. In fact, medical issues will dominate the Legislature for the remainder of the 1980s.

What can we do? We can:

(1) Become more active in the political process. We can work for and support candidates early and during the election campaigns.
(2) Get to know each local legislator. One good way is to invite each one to dinner in your home, especially during the early fall.
(3) Contribute to GAMPAC. Do *you* belong?
(4) Keep informed on legislative issues that affect your practice.

How can "busy" doctors take time for this? The MAG makes it easier for you with the written material provided in the *Journal* and MAG Newsletter, and also in the Legislative Bulletin sent out weekly during the legislative session.

Our Physician Involvement Program (PIP) was begun several years ago and has been a useful means of getting more physicians involved in the legislative process. You will soon have an opportunity to volunteer for PIP and come to the Capitol for at least 1 day during the upcoming session which begins January 14, 1985, and runs through March. Legislators are very cognizant of a number of Georgia doctors who are interested enough to attend the Legislature every day. Already we know of 28 medically related bills which will be of primary interest to you during the next session. Some of these are indigent care, child abuse, tort reform, x-ray technician licensure, respiratory therapist licensure, expansion in scope of chiropractic, expansion of practice by physical therapists, certificate of need, foreign medical graduates, etc. . . .

It is up to you, as individual medical doctors and members of county medical societies and specialty societies working with and through the MAG, to become involved in the legislative process. The time has come for the "twain" of doctors and legislators to meet on an ongoing basis.

S. William Clark

S. William Clark, Jr., M.D.

the association
the association
the association

NEW MEMBERS

Adcock, Stephen R., Colquitt—ACT (N-2)—ORS/HS
1414 S. Main St., Moultrie 31768

Berg, Joseph C., Dougherty—ACT (N-2)—OPH
810—13th Ave., Albany 31701

Bosshardt, David C., Walker-Catoosa-Dade—ACT (N-2)—IM
150 Gross Crescent, Fort Oglethorpe 30742

Clark, Spurgeon William, III, Ware—ACT (N-2)—OPH
502 Isabella St., P. O. Box 2009, Waycross 31502

Hunter, Richard G., Gwinnett-Forsyth—ACT—N
719 Scenic Hwy., Ste. D., Lawrenceville 30245

Ingram, Richard L., Troup—ACT (N-2)—IM/NEP
301 Medical Park, LaGrange 30240

Ivanovic, Zoran, Coweta—ACT—GP
215 Johnson St., Senoia 30276

Kaplan, Lawrence D., Gwinnett-Forsyth—ACT (N-2) IM-PUD
3997 Lawrenceville Hwy., Ste 233-B, Lilburn 30247

Kelso, William R., II, South Georgia—ACT (N-1)—EM
South Georgia Medical Center, Valdosta 31601

LaVine, Alan D., Richmond—ACT (N-2) IM/NEP
820 St. Sebastian Way, SE, Augusta 30901

Levine, Stanley I., Muscogee—ACT—PD
The Medical Center, 710 Center St., Columbus 31907

Lurye, Donald R., Cobb—ACT (N-1)—FP
Urban Family Practice Assoc., PC, 2550 Windy Hill Rd., Ste. 307, Marietta 30067

Malizia, Anthony A., Jr., Clayton-Fayette—ACT (N-2)—U
33 S.W. Upper Riverdale Rd., Ste. 112, Riverdale 30274

Pentzien, Roger J., Glynn—ACT (N-2)—P
1103 Fountain Lake Dr., Brunswick 31520

Phelts, Angus P., III, Richmond—I&R—OTO
847 Kamel Dr., Augusta 30909

Rosing, Howard S., Cobb—ACT (N-2)—N
522 North Ave., Marietta 30060

Shah, Jay J., Gwinnett-Forsyth—ACT (N-1)—ORS
455 Beaver Ruin Rd., Ste. 104, Lilburn 30247

Spiro, Jean F., Richmond—ACT—R
1450 Winter St., Augusta 30910

Steinfeld, Jesse L., Richmond—ACT—IM/HEM
Medical College of Georgia, Augusta 30912

Taleb, Mostefa, Richmond—ACT—R
625 Wrights Ave., Augusta 30904

Terry, Glenn C., Muscogee—ACT—ORS
6262 Hamilton Rd., Columbus 31995

Thomas, Ben D., Jr., Douglas—ACT (N-2)—FP
Urgent Care Center, Munday Mill Rd., Oakwood 30566

Wallace, Thomas E., Cobb—ACT—IM/PUD
1001 Thornton Rd., Box 10, Lithia Springs 30057

Weiss, William D., Hall—ACT (N-2)—ORS
660-A Lanier Park Dr., NE, Gainesville 30505

Williamson, Gary B., Richmond—ACT—GS/PS
2100 Central Ave., Augusta 30904

Young, George M., Southwest Georgia—ACT (N-2)—GP/OBG
Gopher Ridge, Box 227-A, Rt. 1, Fort Gaines 31751

PERSONALS

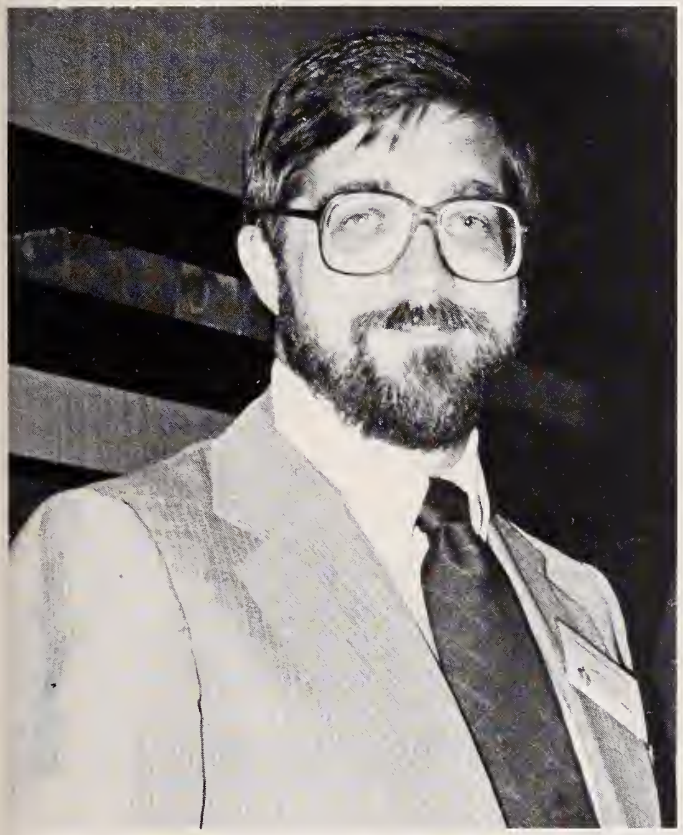
Fifth District

Robert F. Egan, M.D., is the newly appointed chief of internal medicine at North Fulton Medical Center. Dr. Egan is an internist who came to practice in Roswell from Alatoona, PA earlier this year.

Ramie A. Tritt, M.D., has recently accepted the position of chief of otolaryngology at North Fulton Medical Center.

Sixth District

William M. McClellan, Jr., M.D., of LaGrange, received a bronze meritorious service medallion from W. D. Hall, Jr., M.D., president of the American Heart Association, Georgia Affiliate. Dr. McClellan was honored for his leadership in a statewide survey of Georgia physicians conducted by the Heart Association in conjunction with the FOCUS (Focus on Coordination of Unified Services) project. The subject of the survey was hypertension management and was the feature article in the April, 1984, *Journal*. Based on the survey, Dr. McClellan helped develop two slide-tape programs that are being presented at hospital staff meetings throughout the state by a network of physician members of the Heart Association. Dr. McClellan also served a 2-year term as



William M. McClellan, Jr., M.D., of LaGrange, honored by the Georgia Affiliate of the American Heart Association.

chairman of the Georgia Affiliate's High Blood Pressure Committee. The award was presented at the Heart Association's 36th Annual Meeting in Atlanta.

Seventh District

Mark A. Gould, M.D., chief executive officer and medical director of Brawner Psychiatric Institute in Smyrna, has been appointed to serve as a member of the American Hospital Association's Council on Patient Services.

Tenth District

Stephen Boyle, M.D., and **Millard Ross, M.D.,** of Rockdale County, were elected to the Georgia Surgical Society.

Conyers physician, **Romulo Parungao, M.D.,** was inducted into the American College of Internal Physicians.

Evelyn L. Weissman, M.D., a Louisville surgeon, has been named a Diplomate of the American Board of Surgery.

AUXILIARY NEWS

The Auxiliary to the MAG held their Winter Board meeting at the Terrace Garden Inn in Atlanta on November 12 and 13.

The first session opened with the usual ceremonies and reports from the state officers. A seminar dealing with communication in a variety of circumstances entitled, "Getting Your Message Across" was conducted by Mr. Craig Aronoff, Ph.D., of Kennesaw College, Marietta.

The luncheon speaker, Mrs. Virginia Kutait (Kemal), who is the Southern Region Vice-President from the AMA-Auxiliary, stressed the importance of physicians' spouses being actively involved in legislation.

A special presentation was made to Mr. L. B. Storey, Business Manager of MAG, and to Mr. Ken Williams, MAG's Director of Communications, for their years of service and devotion to the Auxiliary to MAG. Both Mr. Storey and Mr. Williams will be leaving MAG in December.

Mrs. Glenda Bates (John G.), Past President of the AMA-Auxiliary, conducted a Leadership Workshop, and Mrs. Jan Collins (William) conducted an AMA-ERF auction to raise money for this worthwhile project. County Auxilians brought handcrafted articles and homemade food to sell.

County presidents made presentations about programs in their counties. An added attraction was a film on Pre and Post Natal Care which counties were encouraged to show in schools as part of the "Shape Up For Life" emphasis for 1984-85.

DEATHS

William Patrick Smith, Jr.

William Patrick Smith, Jr., M.D., 76, of Stone Mountain, died September 23. Dr. Smith was retired. He had served as team doctor for Avondale and Towers High School football teams and was the doctor for the Methodist Childrens Home in Decatur. He was instrumental in starting DeKalb General Hospital.

Dr. Smith is survived by his wife, three sons, and six grandchildren.

Albert Lawrence Stone

Albert Lawrence Stone, M.D., 59, a pediatrician from Fayetteville, died October 20. Dr. Stone served in the Army Air Corps in World War II. He was a graduate of Dufts University and Yale University Medical School.

Survivors include his wife, one daughter, two sons, and two brothers.

Letter to the Editor . . .

Psychiatry and the Courtroom

Dear Editor,

As a physician, I am embarrassed by the conflicting psychiatric testimony so common in prominent trials across the land, most recently in the case of the policeman convicted of armed robbery at the Atlanta Stadium.

The psychiatric condition of multiple personalities is extremely rare in the general population but seems almost epidemic among those on trial for violent crimes with associated severe penalties. Few pathologists would voluntarily testify on controversial subjects without some forensic training, but a few psychiatrists seem ready, willing, and able to testify with conviction where angels fear to tread.

I am in favor of the AMA position to stay out of insanity cases in court, but if the medical profession needs to be in court, it should be limited to those with adequate forensic training.

Olav H. Alvig, M.D.
Radiologist, Cumming
Oct. 2, 1984

Physician's Recognition Award Recipients

LISTED BELOW *are those physicians in Georgia who have earned the AMA's Physician's Recognition Award (PRA) from July through September 1984.*

The Award was established in 1969 "to recognize, encourage, and support physicians who participate regularly in continuing medical education and to emphasize the importance of developing more meaningful continuing medical education opportunities for physicians." A minimum of 150 credit hours of CME must be earned over a 3-year period to qualify for the Award. The hours may include such activities as conferences, residencies, teaching, writing, private reading, listening to cassettes, home study courses, consultation, and peer review; at least 60 of the hours, however, must be from formal CME programs sponsored or co-sponsored for Category I credit by organizations accredited for these activities.

The MAG House of Delegates has set a goal that all MAG members shall have received the PRA by 1985. We congratulate the following physicians who have distinguished themselves and their profession by their commitment to continuing education:

William L. Amos, Columbus
William S. Bikoff, Atlanta
Larry Bregman, Atlanta
John K. Burns, Gainesville
James A. Campbell, Fitzgerald
George D. Clarke, Savannah
William J. Degenhart, Savannah
Mohamed N. Dharamsi, Conyers
Taher A. M. El Gammal, Augusta
John M. Epley, Decatur
Henry J. Ford, Athens
John A. Fountain, Conyers
Thomas A. Getman, Hahira
Glenn A. Gingold, Norcross
John A. Goldman, Atlanta
Francisco E. Gonzalez, Canton
Jose M. Gonzalez, Milledgeville
Meir Gur-Lavi, Austell
Carol A. Harpe, Gainesville
Lewis B. Hasty, East Point
David L. Hatmaker, Athens
Paul J. Jarrett, Decatur
Allyn C. Johnson, Gainesville
Janice S. Johnston, Atlanta
Jonsey J. Jones, Tucker
A. Paul Keller, Athens
Edward N. Laman, Atlanta
William C. Lang, Atlanta
Steve Z. Lintymer, Columbus
Max P. Lorenz, Marietta
James K. McDonald, Augusta
Ray L. McKinney, Albany
Clinton E. Massey, Augusta
Jason L. Meadors, Valdosta
Karl S. Mihalovits, Smyrna
Bess I. Miller, Atlanta
Virginia G. Mork, Atlanta
Michael S. Mull, Marietta
Aliman B. Neal, Augusta
Philip E. Newman, Atlanta
Alexander T. Parkinson, Snellville
James M. Perkins, Atlanta
Ermete E. Pierleoni, Alto
Dionisio A. Pinero, Milledgeville
Quentin R. Pirkle, Atlanta
Susan E. Platt, Stone Mountain
Alan J. Pomerance, Tucker
Lance E. Radbill, Rossville
Warren A. Rasmussen, Brunswick
Humberto C. Ravelo, Milledgeville
Virginia M. Gould Reynaud, Atlanta
John C. Richards, Fort Benning
David B. Roberts, Columbus
Roger M. Rossomondo, Carrollton
Manuel V. Salamanca, Columbus
Elio S. Sanchez, Rome
Robert L. Schwin, Atlanta
Nison H. Shleifer, Atlanta
William E. Silver, Atlanta
Gerardo L. Sotomayor, Marietta
Robert T. Steller, Moultrie
David G. Stroup, East Point
David C. Thibodeaux, Marietta
Martin L. Throne, Atlanta
David A. Turner, Albany
John L. Waller, Atlanta
William I. Waller, Savannah
Francis M. Watson, Atlanta
Richard A. Wherry, Dahlonega
Stephen R. White, Statesboro
William H. White, Gainesville
Leslie L. Wilkes, Savannah

Medical Student Section . . .

Georgia Medical Students Organize Chapter

As medical students across the nation take a more active role in the American Medical Association, the Georgia student members of MAG have established themselves as a statewide organization. The four schools — Emory, Medical College of Georgia, Morehouse, and Mercer — are well-represented in the newly formed MAG-Medical Student Section. The AMA sent a staff member to Atlanta last spring to help MAG-MSS in its initial stages, but student leadership has effected the success of the group. The medical students of MAG-MSS are committed to increasing membership, since it is today's students who will lead the medical community tomorrow. The MAG-MSS goal to increase student membership in the MAG to 1,000 is already in sight. Toward that end, the students are proposing a streamlined application procedure for joining. In addition, the MAG-MSS is striving to increase student participation on the local, state, and national levels on established councils and committees. With MAG support, the Student Section published its first statewide newsletter in October. This monthly publication reaches all Georgia medical students in an attempt to involve them in the affairs that will directly affect their professional lives. Through this forum, communication among medical students is fostered, and they begin to work together more closely.

Georgia is well-represented at the national level with several medical student leaders taking active roles at the recent AMA Interim Convention in Honolulu. In keeping with the current grass roots movement of the AMA, one-to-one peer recruitment has taken the front seat to many priorities in the MAG-MSS. As Georgia medical students continue to participate actively at all levels in the AMA, the MAG will benefit by recruiting and retaining members from the outset of the professional careers. *(Reported by Mark S. Litwin, Emory University School of Medicine '85, Atlanta.)*

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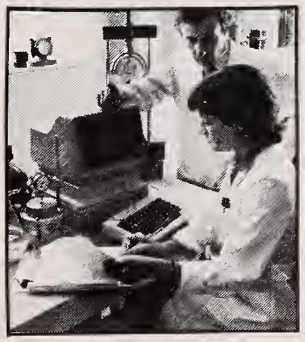
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Medical Software



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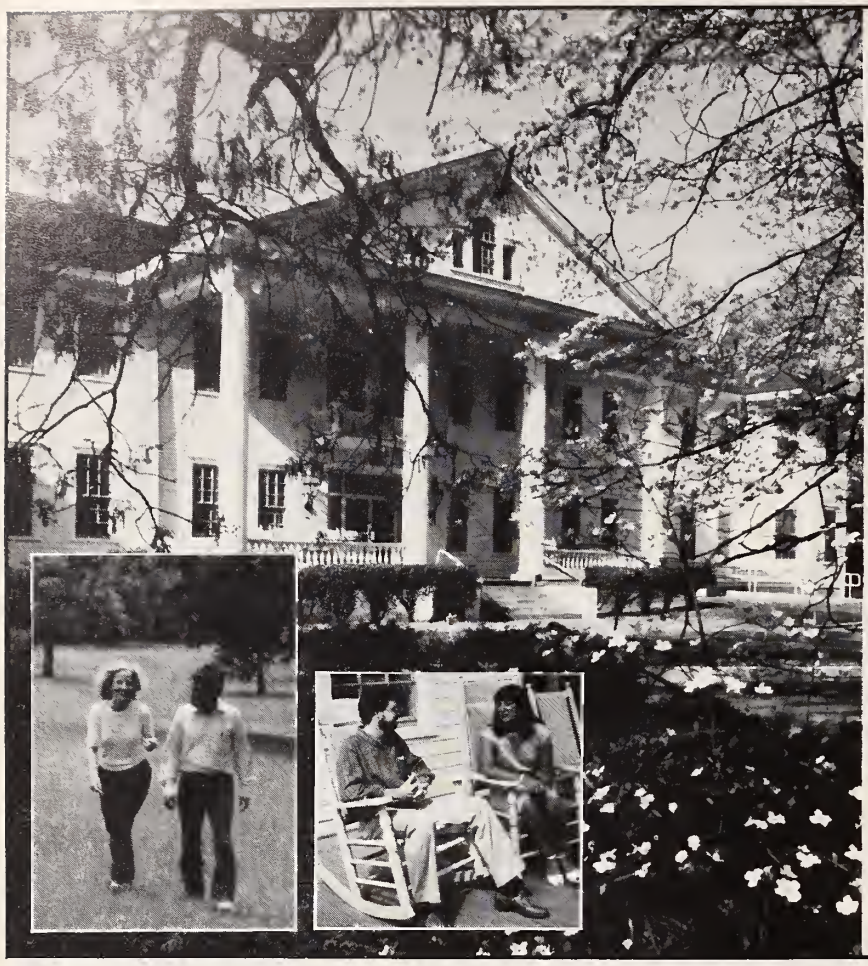
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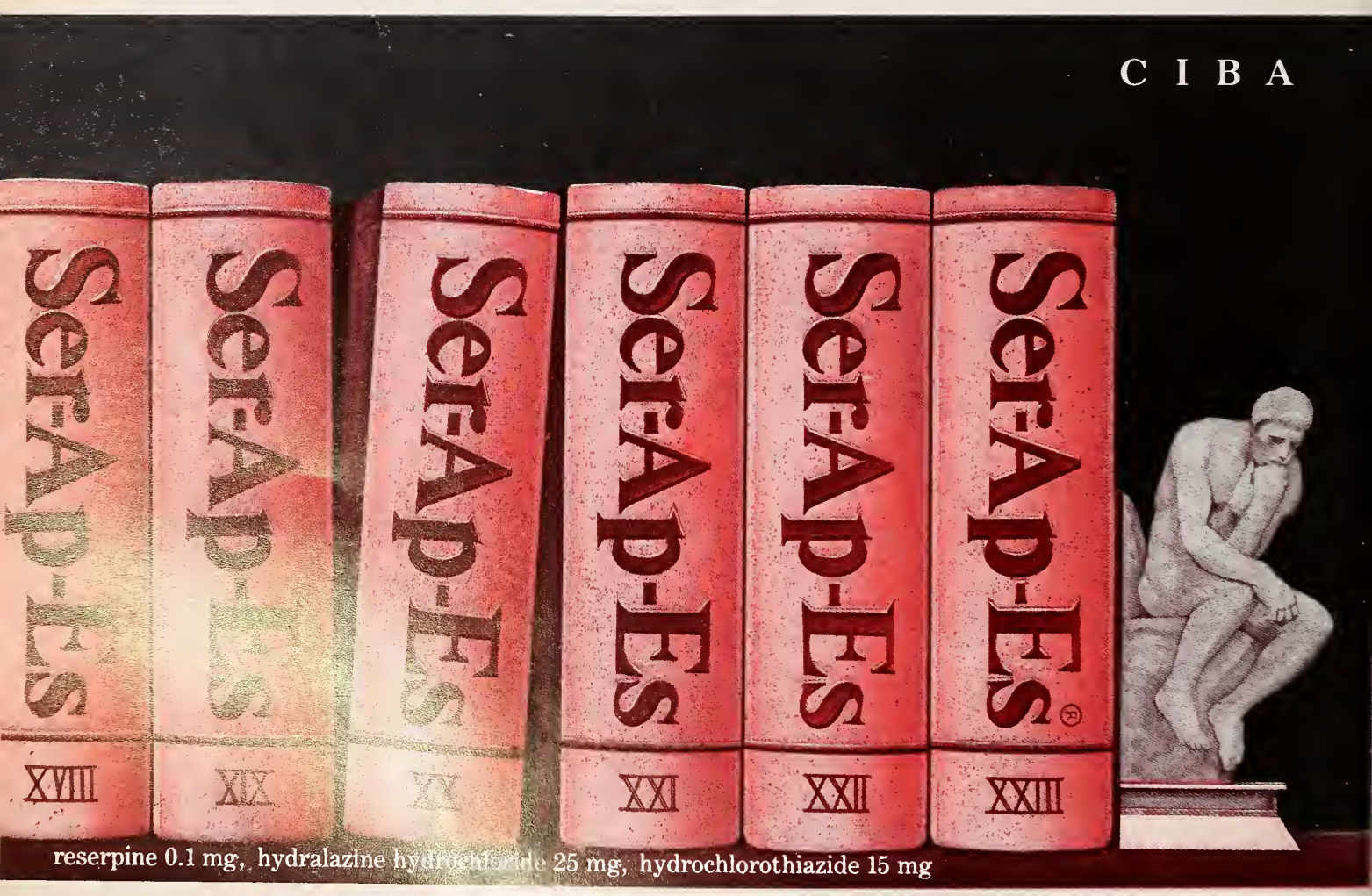
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Please turn the page for a brief summary of prescribing information.

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Contraindications: Anaphylactoid reactions have occurred in individuals hypersensitive to *Motrin* Tablets or with the syndrome of nasal polyps, angioedema and bronchospastic reactivity to aspirin, iodides, or other nonsteroidal anti-inflammatory agents.

Warnings: Peptic ulceration and GI bleeding, sometimes severe, have been reported. Ulceration, perforation and bleeding may end fatally. An association has not been established. Use *Motrin* Tablets under close supervision in patients with a history of upper gastrointestinal tract disease, after consulting ADVERSE REACTIONS. In patients with active peptic ulcer and active rheumatoid arthritis, try nonulcerogenic drugs, such as gold. If *Motrin* Tablets are used, observe the patient closely for signs of ulcer perforation or GI bleeding.

Chronic studies in rats and monkeys have shown mild renal toxicity with papillary edema and necrosis. Renal papillary necrosis has rarely been shown in humans treated with *Motrin* Tablets.

Precautions: Blurred and/or diminished vision, scotomata, and/or changes in color vision have been reported. If these develop, discontinue *Motrin* Tablets and the patient should have an ophthalmologic examination, including central visual fields and color vision testing.

Fluid retention and edema have been associated with *Motrin* Tablets; use with caution in patients with a history of cardiac decompensation or hypertension. In patients with renal impairment, reduced dosage may be necessary. Prospective studies of *Motrin* Tablets safety in patients with chronic renal failure have not been done.

Motrin Tablets can inhibit **platelet aggregation** and prolong bleeding time. Use with caution in persons with intrinsic coagulation defects and on anticoagulant therapy.

Patients should report signs or symptoms of **gastrointestinal ulceration** or bleeding, skin rash, weight gain, or edema.

Patients on prolonged **corticosteroid therapy** should have therapy tapered slowly when *Motrin* Tablets are added.

The antipyretic, anti-inflammatory activity of *Motrin* Tablets may mask inflammation and fever.

As with other nonsteroidal anti-inflammatory drugs, borderline elevations of liver tests may occur in up to 15% of patients. These abnormalities may progress, may remain essentially unchanged, or may be transient with continued therapy. Meaningful elevations of SGPT or SGOT (AST) occurred in controlled clinical trials in less than 1% of patients. Severe hepatic reactions, including jaundice and cases of fatal hepatitis, have been reported with ibuprofen as with other nonsteroidal anti-inflammatory drugs. If liver disease develops or if systemic manifestations occur (e.g. eosinophilia, rash, etc.), *Motrin* should be discontinued.

Drug interactions. *Aspirin:* used concomitantly may decrease *Motrin* blood levels.

Coumarin: bleeding has been reported in patients taking *Motrin* and coumarin.

Pregnancy and nursing mothers: *Motrin* should not be taken during pregnancy or by nursing mothers.

Adverse Reactions: The most frequent type of adverse reaction occurring with *Motrin* is gastrointestinal of which one or more occurred in 4% to 16% of the patients.

Incidence Greater than 1% (but less than 3%)—Probable Causal Relationship

Gastrointestinal: Nausea,* epigastric pain,* heartburn,* diarrhea, abdominal distress, nausea and vomiting, indigestion, constipation, abdominal cramps or pain, fullness of GI tract (bloating and flatulence); **Central Nervous System:** Dizziness,* headache, nervousness; **Dermatologic:** Rash* (including maculopapular type), pruritus; **Special Senses:** Tinnitus; **Metabolic/Endocrine:** Decreased appetite; **Cardiovascular:** Edema, fluid retention (generally responds promptly to drug discontinuation; see PRECAUTIONS).

Incidence less than 1%—Probable Causal Relationship**

Gastrointestinal: Gastric or duodenal ulcer with bleeding and/or perforation, gastrointestinal hemorrhage, melena, gastritis, hepatitis, jaundice, abnormal liver function tests; **Central Nervous System:** Depression, insomnia, confusion, emotional lability, somnolence, aseptic meningitis with fever and coma; **Dermatologic:** Vesiculobullous eruptions, urticaria, erythema multiforme, Stevens-Johnson syndrome, alopecia; **Special Senses:** Hearing loss, amblyopia (blurred and/or diminished vision, scotomata, and/or changes in color vision) (see PRECAUTIONS); **Hematologic:** Neutropenia, agranulocytosis, aplastic anemia, hemolytic anemia (sometimes Coombs positive), thrombocytopenia with or without purpura, eosinophilia, decreases in hemoglobin and hematocrit; **Cardiovascular:** Congestive heart failure in patients with marginal cardiac function, elevated blood pressure, palpitations; **Allergic:** Syndrome of abdominal pain, fever, chills, nausea and vomiting; anaphylaxis; bronchospasm (see CONTRAINDICATIONS); **Renal:** Acute renal failure in patients with pre-existing significantly impaired renal function, decreased creatinine clearance, polyuria, azotemia, cystitis, hematuria; **Miscellaneous:** Dry eyes and mouth, gingival ulcer, rhinitis.

Incidence less than 1%—Causal Relationship Unknown**

Gastrointestinal: Pancreatitis; **Central Nervous System:** Paresthesias, hallucinations, dream abnormalities, pseudotumor cerebri; **Dermatologic:** Toxic epidermal necrolysis, photoallergic skin reactions; **Special Senses:** Conjunctivitis, diplopia, optic neuritis; **Hematologic:** Bleeding episodes (e.g., epistaxis, menorrhagia); **Metabolic/Endocrine:** Gynecomastia, hypoglycemic reaction; **Cardiovascular:** Arrhythmias (sinus tachycardia, sinus bradycardia); **Allergic:** Serum sickness, lupus erythematosus syndrome, Henoch-Schonlein vasculitis; **Renal:** Renal papillary necrosis.

*Reactions occurring in 3% to 9% of patients treated with *Motrin*. (Those reactions occurring in less than 3% of the patients are unmarked.)

**Reactions are classified under *"Probable Causal Relationship (PCR)"* if there has been one positive rechallenge or if three or more cases occur which might be causally related. Reactions are classified under *"Causal Relationship Unknown"* if seven or more events have been reported but the criteria for PCR have not been met.

Overdosage: In cases of acute overdosage, the stomach should be emptied. The drug is acidic and excreted in the urine so alkaline diuresis may be beneficial.

Dosage and Administration: Rheumatoid arthritis and osteoarthritis. Suggested dosage is 300, 400, or 600 mg t.i.d. or q.i.d. Do not exceed 2400 mg per day. Mild to moderate pain: 400 mg every 4 to 6 hours as necessary

Caution: Federal law prohibits dispensing without prescription.

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Kalamazoo, Michigan 49001

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August, 1984



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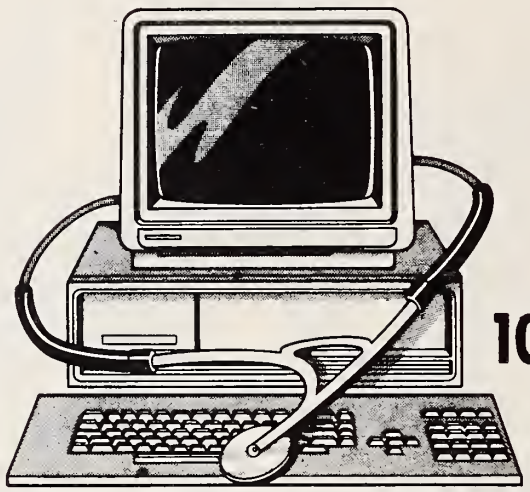
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Charter By-the-Sea

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L — Legal Page
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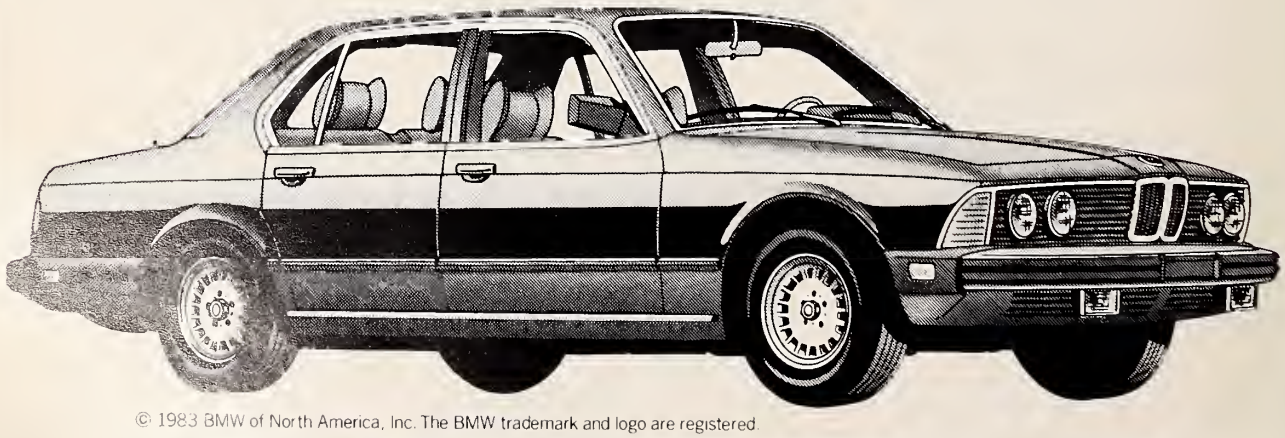
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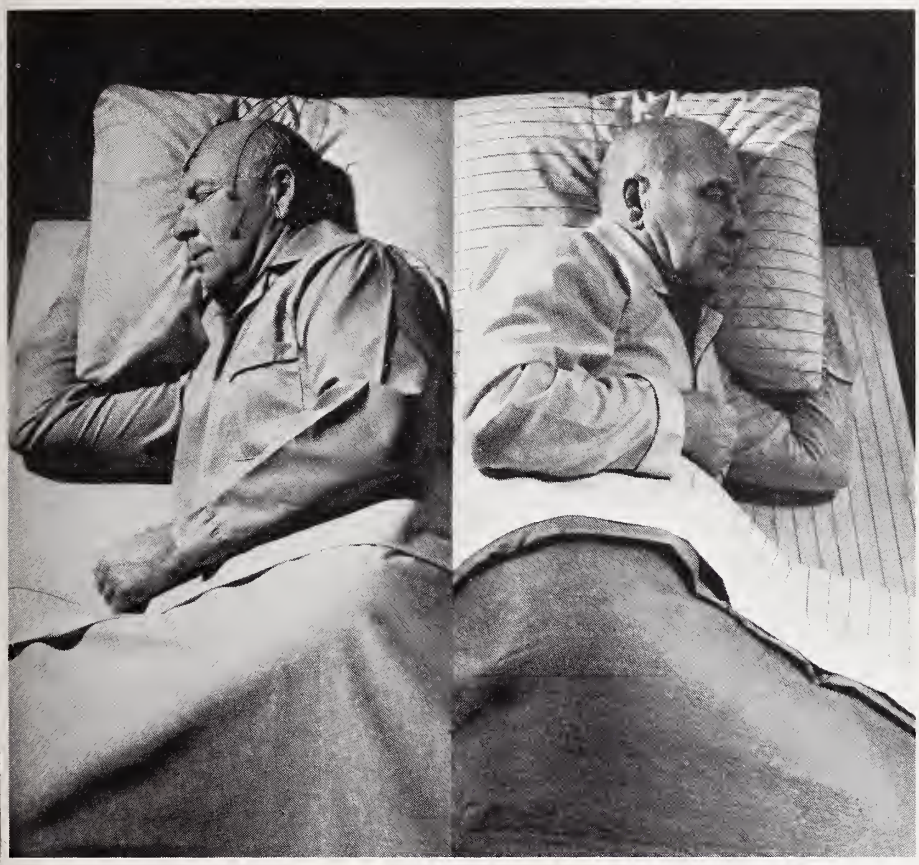
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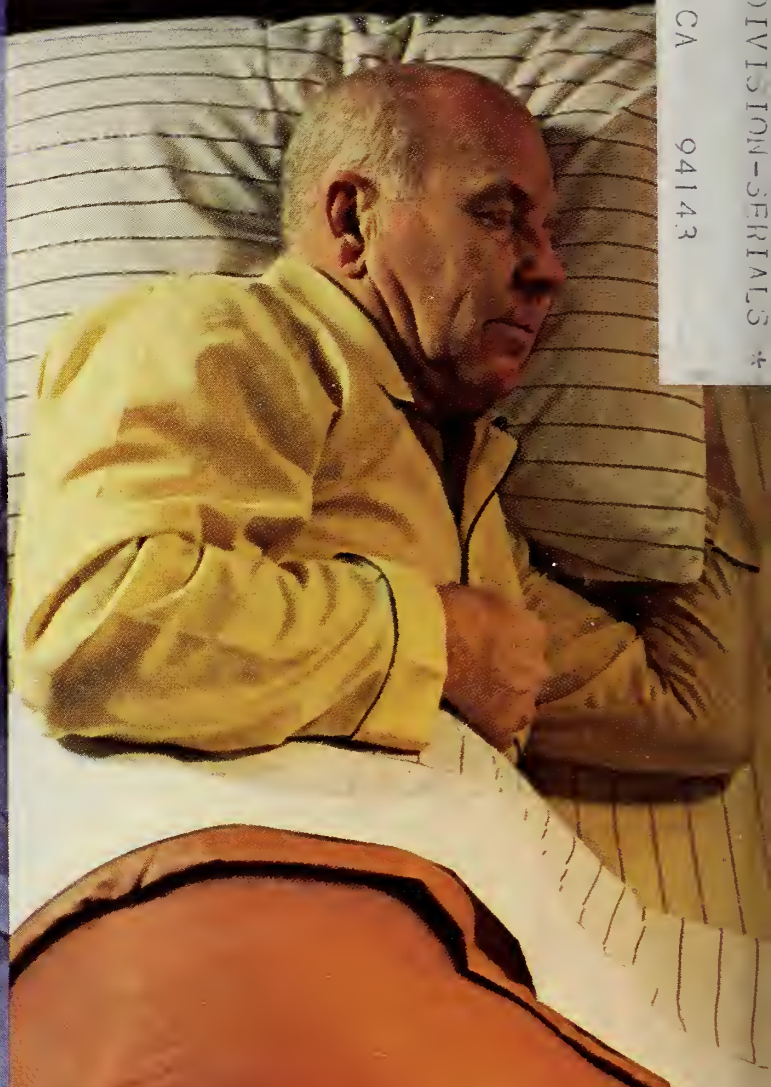
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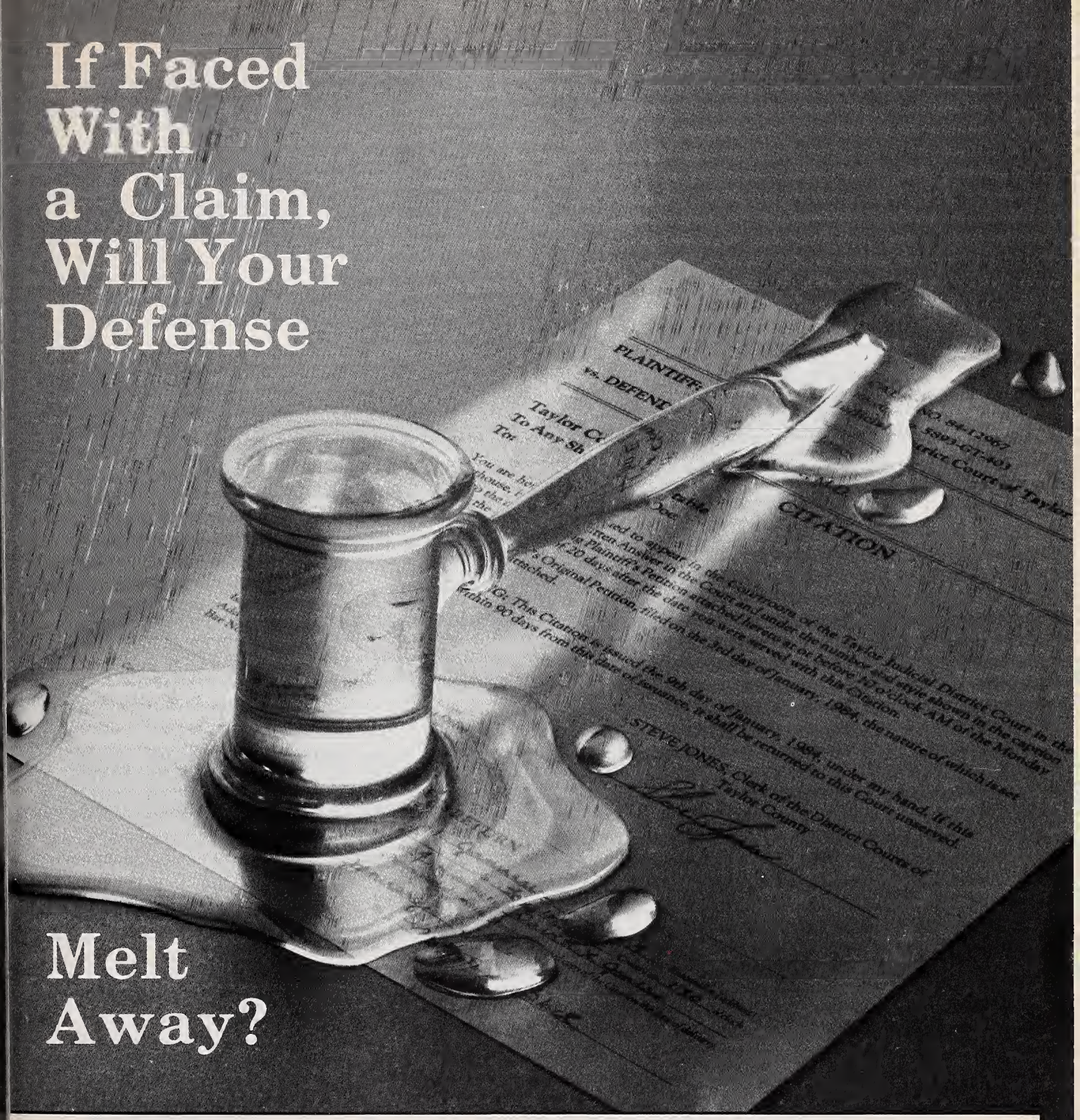
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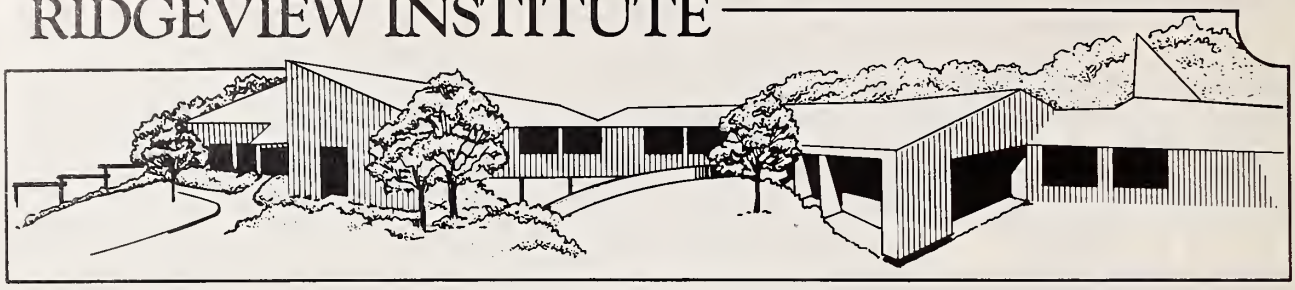
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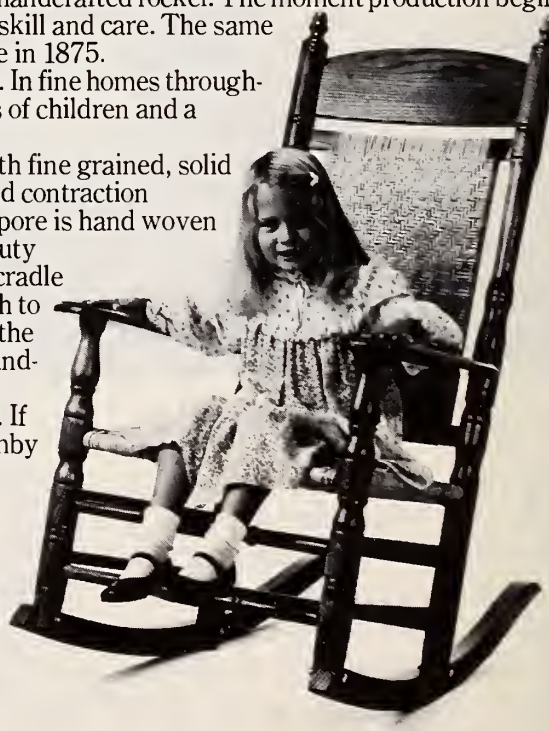
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1	Leon E. Curry, Metter	(912) 685-5715 ('85)	Richard I. Staiman, Statesboro	(912) 764-6671 ('85)
2	Sammie Dixon, Tifton	(912) 382-0375 ('85)	Lannie Copeland, Moultrie	(912) 985-3320 ('85)
3	Virgle W. McEver, Jr., Warner Robins	(912) 923-0144 ('85)	Wentford A. Spears, Warner Robins	(912) 923-0106 ('85)
6	Samuel A. Brewton, Jr., Thomaston	(404) 647-9412 ('86)	Norman P. Gardner, Thomaston	(404) 647-5401 ('86)
7	Bannester L. Harbin, Rome	(404) 295-5990 ('86)	John Atha, Rockmart	(404) 684-7846 ('86)
8	Joe C. Stubbs, Valdosta	(912) 244-4720 ('87)	S. William Clark, Jr., Waycross	(912) 283-4876 ('87)
9	Rupert H. Bramblett, Cumming	(404) 887-5055 ('87)	C. Peter Lampros, Toccoa	(404) 886-3148 ('87)
10	Wm. M. Headley, Milledgeville	(912) 452-4608 ('85)	Charles Wills, Washington	(404) 678-2181 ('85)
Bibb County Medical Society				
	Beverly B. Sanders, Macon	(912) 745-8581 ('87)	Charles A. Lanford, Macon	(912) 788-3746 ('87)
Clayton-Fayette Medical Society				
	Selwyn T. Hartley, Riverdale	(404) 991-0997 ('87)	F. Peter Nicholson, Riverdale	(404) 766-7151 ('87)
Cobb County Medical Society				
	Dan B. Stephens, Marietta	(404) 427-0285 ('85)	Ronald Roper, Marietta	(404) 428-4413 ('85)
Crawford W. Long Medical Society				
	William C. Holmes, Athens	(404) 543-6704 ('85)	E. Van Herrin, Athens	(404) 548-4272 ('85)
DeKalb Medical Society				
	H. Duane Blair, Decatur	(404) 378-3514 ('87)	Charles W. McDowell, Jr., Decatur	(404) 292-2500 ('87)
Dougherty County Medical Society				
	Frank F. Middleton, III, Albany	(912) 883-7012 ('86)	Carl V. Hancock, Jr., Albany	(912) 883-1503 ('86)
Floyd-Polk-Chattooga Medical Society				
	Robert A. Farrell, Rome	(404) 291-2715 ('87)	Joel Todino, Rome	(404) 295-3961 ('87)
Hall County Medical Society				
	John Reed, Gainesville	(404) 534-0711 ('86)	James H. Leigh, Jr., Gainesville	(404) 536-2323 ('86)
Medical Association of Atlanta				
	William C. Collins, Atlanta	(404) 255-4582 ('86)	Bob G. Lanier, Atlanta	(404) 351-0130 ('86)
	Thomas J. Anderson, Jr., Atlanta	(404) 688-5971 ('87)	W. Ben Spearman, Atlanta	(404) 881-8884 ('87)
	J. Harold Harrison, Atlanta	(404) 524-4707 ('85)	William C. Waters, III, Atlanta	(404) 355-1966 ('85)
Georgia Medical Society				
	Joe L. Nettles, Savannah	(912) 355-0140 ('85)	Clyde L. Olson, Savannah	(912) 352-7941 ('85)
Muscogee County Medical Society				
	Jack A. Raines, Columbus	(404) 563-5231 ('86)	E. M. (Mac) Molnar, Columbus	(404) 324-3661 ('86)
Richmond County Medical Society				
	Luther M. Thomas, Augusta	(404) 733-3406 ('87)	Sumner Fishbein, Augusta	(404) 722-3458 ('87)
	James L. O'Quinn, Augusta	(404) 863-3766 ('87)	Donald C. Abele, Augusta	(404) 828-3291 ('87)

AMA DELEGATES AND ALTERNATE DELEGATES, JANUARY 1, 1985

Delegates	Term Ending	Alternate Delegates	Term Ending
J. Dan Bateman, Albany	1986	S. William Clark, Jr., Waycross	1986
C. Emory Bohler, Brooklet	1985	Joe C. Stubbs, Valdosta	1986
H. Hilt Hammett, Jr., LaGrange	1986	C. Peter Lampros, Toccoa	1985
William W. Moore, Jr., Atlanta	1985	James H. Sullivan, Columbus	1986
Carson B. Burgstiner, Savannah	1986	L. Newton Turk, III, Atlanta	1985
Charles D. Hollis, Jr., Albany	1985	Virgle W. McEver, Warner Robins	1985

MAG COMMITTEE STRUCTURE

(June 1, 1984 — May 31, 1985)

COUNCIL ON ADMINISTRATION

Council Chairman: William W. Moore, Jr., Atlanta

CHARGE: The Council on Administration shall advise, direct, and manage the administrative affairs of the MAG subject to approval by the Board of Directors and shall coordinate these functions with the administrative staff of the Association.

ANNUAL SESSION: The Committee on Annual Session shall carry out the approved policies of the Association as directed by the Board of Directors. It shall study and make recommendations concerning the Annual Session of the Association. The Committee shall submit a budget for the Annual Session to the Finance Committee.

President, MAG
President-Elect, MAG
Speaker, House of Delegates
Vice Speaker, House of Delegates
MAG Staff, Michael Fowler

BUILDING AND LAND: The Building and Land Committee shall be responsible in an advisory capacity for evaluating all significant additions and/or alterations of a structural nature to the MAG Headquarters building and land; shall evaluate any offers to purchase, sell or lease said building and land or other real estate, in part or in toto, and shall submit to the Council on Administration a report on all activities with accompanying fiscal data along with the Committee's recommendation for a plan of action.

H. Duane Blair, Decatur, CHAIRMAN
J. Harold Harrison, Atlanta
S. William Clark, Jr., Waycross
James A. Kaufmann, Atlanta
Beverly Sanders, Jr., Macon
MAG Staff, Hoyt Torras

CONSTITUTION & BYLAWS: The Committee shall be responsible for the continuing study of the organization of the MAG. It shall recommend to the House of Delegates through the Council on Administration and the Board of Directors any amendments or revisions which seem necessary or advisable. At least every five years, the Committee shall recommend revisions after a complete study of the organization of the Association and its Constitution and Bylaws. Proposed amendments shall be referred to the Committee on Constitution and Bylaws for recommendation before action thereon is taken by the House of Delegates.

J. Rhodes Haverty, Atlanta, CHAIRMAN
Charles Andrews, Canton
Charles G. Burton, Macon
A. Delone Muse, Athens
E. V. Patrick, Carrollton
Richard W. Cohen, Austell
Walker Ray, Decatur
MAG Staff, Michael R. Fowler

FINANCE: All expenditures made by the Local Arrangements Committee in connection with the Annual Session must be authorized in advance by the Committee on Finance. The Board of Directors shall have control of all commercial exhibits of the Annual Session and any deficit created on account of the Annual Session shall be met by the Board of Directors on recommendation of the Committee on Finance.

Cyler D. Garner, Gordon, CHAIRMAN
Carson B. Burgstiner, Savannah
Frank F. Middleton, III, Albany
Bob G. Lanier, Atlanta
MAG Staff, L. B. Storey

MEMBERSHIP COMMITTEE: Develop recruitment programs to attract new members and to retain present members.

John T. Yauger, Secretary
Cyler D. Garner, Treasurer
William D. Logan, Jr., President-Elect
MAG Staff, Ken Williams

TRUSTEE ADVISORY COMMITTEE: The Trustee Advisory Committee shall be composed of the Association's Treasurer, Secretary, Executive Director, and a Past President of the Association. The Treasurer shall be Chairman. The charge of the Trustee Advisory Committee shall be to oversee the Retirement Fund of the Association.

Cyler D. Garner, Gordon, CHAIRMAN
John T. Yauger, Atlanta, Secretary
Carson B. Burgstiner, Savannah, Past President
Michael R. Fowler, Executive Director
MAG Staff, L. B. Storey

COMPUTER ADVISORY: The Committee shall have general oversight responsibility for the computer activities of the Information Systems Department. It will review with Information Systems staff all budget requests, as well as all new projects of significant size and impact, and will make reports to the Council on Administration.

John D. Watson, Jr., Columbus, CHAIRMAN
Virgle W. McEver, Jr., Macon
Cyler D. Garner, Gordon
L. Newton Turk, III, Atlanta
Charles R. Underwood, Marietta
MAG Staff, Hoyt Torras

MAG/GMCF ADVISORY COMMITTEE: The Committee will design review proposals and translate the requirements to be imposed by the Federal Government into a specific review process to be administered by the Foundation.

Representatives of MAG:
M. D. Pittard, Toccoa
Ollie O. McGahee, Jesup
W. Earl Bobo, Decatur
Harry N. Dorsey, Albany
George J. Everidge, Columbus
Bob G. Lanier, Atlanta

Representatives of GMCF:
Joe L. Nettles, Savannah
Jack F. Menendez, Macon
E. M. Molnar, Columbus
E. Van Herrin, Athens
Luther M. Thomas, Augusta

MAG/MAG MUTUAL STUDY COMMITTEE:

S. William Clark, Jr., Waycross, CHAIRMAN
Phil Israel, Atlanta
John Heard, Atlanta
Jack F. Menendez, Macon
Cyler D. Garner, Gordon
Joe Wilson, Atlanta

COUNCIL ON LEGISLATION

Council Chairman: James A. Kaufmann

CHARGE: Established to continually review pending legislation, active bills, and the need for particular legislation; recommend positions of policy to policymaking bodies to MAG; and communicate the MAG position to congressmen and state legislators.

James A. Kaufmann, Atlanta, CHAIRMAN
Paul Beecham, Marietta
Mrs. William C. (Jan) Collins, Atlanta
H. Gordon Davis, Sylvester
Arthur R. Evans, College Park
George Hubbard, Jr., Columbus
Mark Hutto, Dunwoody
J. R. B. Hutchinson, Tucker
W. Scott James, Atlanta
Gilbert Kelmann, Albany
W. Frank Matthews, Decatur
James S. Maughon, Atlanta
Stephen C. May, Marietta
Jeffrey T. Nugent, Atlanta
Beverly B. Sanders, Jr., Macon
Eloise Sherman, Savannah
W. Douglas Skelton, Atlanta
Emory Medical Student
MCG Medical Student
Morehouse Medical Student
MAG Staff, Rusty Kidd

COUNCIL ON COMMUNITY SERVICES

Council Chairman: Frank F. Middleton, III

CHARGE: This Council shall be responsible for those activities of the Association which serve to benefit the community as a whole. Such activities shall encompass public education in the area of health care and other programs which promote the betterment of public health through communication with the service to the lay public.

PUBLIC HEALTH: Established to promote the betterment of the public health in Georgia by developing and distributing educational materials on specific subjects and problems to the public and to the practicing physicians.

O. Grey Rawls, Albany, CHAIRMAN
Benjamin S. Anderson, Cedartown
Gunar N. Bohan, Decatur
William R. Elsea, Atlanta
William C. T. Jernigan, Columbus
S. Charlotte Neuberg, Macon
Benjamin B. Okel, Decatur
Elton S. Osborne, Jr., Atlanta
Wells Riley, Jonesboro
Paul C. White, Albany
Mrs. Maurice (Louise) Patton, Augusta
MAG Staff, Joyce Butler

PRISON HEALTH CARE: Study and recommend ways to improve the delivery and promote the availability of adequate professional health care in Georgia's prisons and jails. This Committee shall provide resources to assist physicians and other health care providers within correctional facilities to meet standards of professional health care as determined by the American Medical Association and this Committee, and to provide those who meet such standards with recognition in the form of accreditation. This Committee shall have responsibilities for liaison with appropriate state agencies and organizations and with other MAG committees in achieving these objectives and shall serve as a resource for physicians who provide care to inmates.

Robert DeJarnette, Vidalia, CHAIRMAN
Charles Allard, Decatur
Mr. Eugene Argo, R.Ph., Decatur (non-voting)
Floyd E. Bliven, Jr., Augusta
Louis G. Chelton, III, Lawrenceville
P. Dennis Gauthier, Jeffersonville
Walter E. Harrison, Moultrie
William A. Hopkins, Atlanta
Leon A. Leonard, D.D.S , Augusta (non-voting)
Cassandra Newkirk, Atlanta (Contingent upon becoming a member)
Arturo Riego (Contingent upon becoming a member)
Henry Robinson, Augusta
Louis Scharff, Gracewood
Douglas Skelton, Atlanta
Patton P. Smith, Forsyth
George Stellings, Warner Robins
Virgil Williams, Griffin
Mrs. Charles Thomas, Athens
MAG Staff, Dorothy Parker

NUTRITION: Charged with the responsibility of investigating and disseminating up-to-date nutritional information which will be provided to MAG members and to the public.

Judson G. Black, Atlanta, CHAIRMAN
Gary August, Columbus
Alfred L. Davis, Jr., Blackshear
Francis W. Fitzhugh, Atlanta
Eugene O. Harrison, Atlanta
W. Dan Jordan, Atlanta
Walter A. Murray, Jr., Norcross
R. Joseph Teague, Augusta
Mrs. David C. Thibodeaux (Barbara), Marietta
Diane K. Smith, Augusta
MAG Staff, Sherry Waronker

MEDICAL ASPECTS OF SPORTS: Established to study the medical problems of the athlete and to provide medical information and advice to coaches and other lay groups who are concerned with athletics.

Letha Y. Hunter, Atlanta, CHAIRMAN
Fred L. Allman, Atlanta
John F. Atha, Rockmart
Robert L. Brand, Augusta
Stephen C. Hunter, Columbus
Joe B. Massey, Atlanta
William B. Mulherin, Athens
William B. Strong, Augusta
David T. Watson, Atlanta
Mrs. William A. Wolff, Columbus
MAG Staff, Susan J. Dillon

MATERNAL & INFANT HEALTH: Established and charged with the responsibility of seeking out information on all aspects of maternal and infant health in Georgia; to cooperate whenever possible (consistent with MAG policy) with appropriate state and local agencies also interested in improving maternal and infant health in Georgia; to serve as liaison among pediatricians, obstetricians, and family physicians; and to make recommendations to the Council on Community Service.

Luella M. Klein, Atlanta, CHAIRMAN
Frank P. Bowyer, Tifton
Joe T. Christmas, Vienna
Richard B. Colditz, Carrollton
Malcolm G. Freeman, Atlanta
Samuel M. Goodrich, Milledgeville
Robert E. Kelley, Athens
William P. Kanto, Jr., Augusta
William W. Leach, Albany
Alva L. Mays, Jr., Macon
Albert Schoenbucher, Atlanta
Richard B. Stewart, Decatur
Joseph R. Swartwout, Macon
Melody A. Stancil, LaGrange
Dan B. Stephens, Marietta
Lillian P. Warnick, Atlanta
Mrs. Jesse Hester, Tifton
MAG Staff, Joyce Butler

EMERGENCY MEDICAL SERVICES: Established to encourage and coordinate Georgia physicians and state and federal agencies to work together in the development of a logical, systematized, and medically sound emergency health services delivery system in Georgia.

Rodger Chapman, Atlanta, CHAIRMAN
H. Hutson Carspecken, Decatur
Thomas Collentine, Marietta
Daniel B. Cox, Waycross
Selwyn Hartley, Riverdale
Mark M. Lindsey, Atlanta
MAG Staff, Joyce Butler

CANCER: Established to provide coordinating relationships between the MAG, the Georgia Department of Human Resources, the Division of Cancer Control, and the Georgia Division of the American Cancer Society, by making policy recommendations to the Council on Community Service on matters relating to cancer and cancer control and overseeing any MAG activity on programs relating to cancer.

J. Moultrie Lee, Savannah, CHAIRMAN
L. C. Buchanan, Decatur
John G. Etheridge, Macon
LaMar S. McGinnis, Jr., Decatur
Douglas A. Murray, Atlanta
E. Capers Palmer, Jr., LaGrange
Neil C. Perkinson, Atlanta
Thomas W. Phillips, Atlanta
Dent Purcell, Savannah
David B. Roberts, Columbus
Joseph A. Wilber, Atlanta
S. Angier Wills, Decatur
John P. Wilson, Atlanta
Chairman of the Board, Georgia Division, American Cancer Society (Ex-Officio)
Executive Vice President, Georgia Division of American Cancer Society (Ex-Officio) Mr. Steve Vaughan
MAG Staff, Patty Winters

ACCESS TO MEDICAL CARE: Established to plan and conduct programs to improve access to medical care in Georgia. A principal method of providing this service is assisting in the recruitment and retention of physicians in localities where there is a need for additional physicians.

M. Julian Duttera, Jr., LaGrange, CHAIRMAN
Benjamin Anderson, Cedartown
J. Price Corr, Albany
L. L. Freeman, Chamblee
Irving D. Hellenga, Toccoa
Cecil Miller, Buford
Elizabeth A. Singletary, Augusta
Mrs. William Tippins, Dunwoody
Donald Waters, Blackshear
Mr. Henry Neal, Atlanta (Ex-Officio, Secretary, State Medical Education Board)
MAG Staff, Monty Nottingham

COUNCIL ON EDUCATION

Council Chairman: Joseph P. Bailey, Augusta

CHARGE: This Council shall be responsible for the development of high quality continuing education programs for physicians throughout the state. It shall also be responsible for promoting health education in schools, public and private, and for promoting health education for the general public.

The Council shall maintain liaison with the medical schools and other institutions and agencies which also provide health and medical education.

The Scientific Assembly Committee, under the direction of the Council on Education, shall plan and conduct such scientific meetings as it considers necessary and beneficial to the membership of the MAG and the medical profession as a whole in the State of Georgia. It shall also plan and conduct meetings relating to the business aspects of the practice of medicine. It shall offer its help and expertise to all allied health organizations who may need or ask for this help.

SCIENTIFIC ASSEMBLY: The Committee shall conduct such general scientific meetings as it considers beneficial to the membership of the MAG and the medical profession as a whole in the State of Georgia, consistent with the affirmed policies of the Association as directed by the Board of Directors and the House of Delegates. The Committee shall submit a budget for these general scientific meetings. The Committee shall consist of a Chairman, appointed by the Executive Committee, and by reason of their offices, the current Chairman of the Committee on Specialty Society Relations and the Chairman of the other committees in the Council of Education.

Ellis B. Keener, Gainesville, CHAIRMAN
Edwin C. Evans, Atlanta
Arthur J. Merrill, Atlanta
Carter Smith, Jr., Atlanta
Roland Summers, Savannah
Chairman of Education Committee (Ex-Officio)
MAG Staff, Steve Davis

CONTINUING MEDICAL EDUCATION: The Committee will foster the development of high-quality continuing medical education (CME) programs for physicians throughout the state, as offered by hospitals, specialty societies, and other agencies which provide medical and health education. As directed by the Accreditation Council for Continuing Medical Education, it will supervise the accreditation of intrastate CME providers. The Committee will also review educational programs sponsored by nonaccredited CME providers and authorize when appropriate the awarding of CME credit.

John A. Harrel, Jr., Decatur, CHAIRMAN
Glen E. Garrison, Augusta
T. Schley Gatewood, Americus
John A. Hudson, Macon
Thomas Johnson, Albany
Robert M. Kolodner, Decatur
Hillary Newland, Athens
Neil G. Perkinson, Atlanta
James S. Maughon, Atlanta
Carl Rosengart, Savannah
Barry Silverman, Atlanta
Mark Silverman, Atlanta
Rodney Smith, Gainesville
Roland Summers, Savannah
William H. Whaley, Atlanta
MAG Staff, Steve Davis

MEDICAL SCHOOLS: The Committee will maintain liaison with the state's medical schools and Talmadge Hospital and will be responsible for planning periodic conferences on medical education on topics pertinent to both practitioners and the medical academic community.

William C. Waters, Atlanta, CHAIRMAN
Ralph E. Berggren, Macon
Lois T. Ellison, Augusta
Frank Ferrier, Atlanta
Harold L. McPheeters, Atlanta
James S. Maughon, Atlanta
George Shannon, Columbus
Kenneth Walker, Stone Mountain
MAG Staff, Steve Davis

HEALTH EDUCATION: The Committee will promote health education in cooperation with hospitals, voluntary health agencies, and other groups, especially those involved in patient education and health education in the schools. The Committee will also assist the MAG Committee on Occupational Health in promoting health education at the workplace.

S. Boyd Eaton, Atlanta, CHAIRMAN
David Apple, Atlanta
Judson G. Black, Atlanta
John Cantwell, Atlanta
J. Rhodes Haverty, Atlanta
Victor A. Moore, Augusta
Barry Silverman, Atlanta
Thomas A. Wade, Columbus
William H. Whaley, Atlanta
MAG Staff, Steve Davis

JUDICIAL COUNCIL

Council Chairman: C. Emory Bohler, Brooklet

CHARGE: a) To serve as the judicial authority of the Association. The decision of the Judicial Council shall be final.

b) To have original jurisdiction with respect to: (1) all questions involving membership as provided in Chapter II of the bylaws; (2) all controversies arising under the Association's Constitution and Bylaws and under

the Principles of Medical Ethics to which the Medical Association of Georgia is a party; (3) all controversies between two or more component societies or their members; (4) the establishment of principles and interpretation of medical ethics; (5) the interpretation of the Constitution and Bylaws and policies of the Association; (6) referrals from component county medical societies when such societies request that the Association assume original jurisdiction of the matter in behalf of such county societies, provided that the Judicial Council approves acceptance of original jurisdiction of such matters; and (7) direct appeals by complainants when the component county medical societies having original jurisdiction have not commenced investigation within 30 days after receipt of the complaint.

c) To have appellate jurisdiction in questions of law and procedure but not of fact in all cases which arise within the Medical Association of Georgia and two or more of its component societies, between a member or members and the component society to which said member or members belong or between members of different component societies of the Association. Notice of appeal shall be filed with the Judicial Council within thirty days of the date of the disputed decision and the appeal shall be perfected within sixty days thereof; provided, however, that the Judicial Council, for what it considers good and sufficient cause may grant an additional thirty days for perfecting the appeal.

d) To receive appeals filed by applicants who allege that they, because of color, creed, race, religion, ethnic origin, national origin, or sex have been unfairly denied membership in a component and/or constituent association, to determine the facts in the case, and to report the findings to the House of Delegates. If the Council determines that the allegations are indeed true, it shall admonish, censure, or, in the event of repeated violations, recommend to the House of Delegates that the component society involved be declared to be no longer a constituent member of the Medical Association of Georgia.

e) To investigate general ethical conditions and all matters pertaining to the relations of physicians to one another or to the public, and make recommendations to the House of Delegates.

f) To request the President to appoint investigating juries to which it may refer complaints or evidences of unethical conduct which in its judgment are of greater than local concern. Such investigating juries, if probable cause of action be shown, shall submit formal charges to the President, who shall appoint a prosecutor to prosecute such charges against the accused before the Judicial Council in the name and on behalf of the Medical Association of Georgia. The Council may acquit, admonish, suspend, or expel the accused.

g) To approve applications and nominate candidates for affiliate membership as otherwise provided for in these bylaws.

C. Emory Bohler, Brooklet, CHAIRMAN
Robert B. Copeland, LaGrange
John M. "Pepper" Martin, Augusta
Hugh F. Smisson, Macon
H. A. Thornton, Greensboro
MAG Staff, Rusty Kidd

COUNCIL ON MEMBERSHIP SERVICES

Council Chairman: E. M. Molnar, Columbus

CHARGE: The benefits of MAG membership, which are the services it provides, shall be made available to prospective and present members. These benefits include professional liability insurance, ongoing assessment of the practice climate, ethical and legal constraints, MAG policies related to membership (hospital relations, paramedical relations, etc.), location assistance, and other services as they become available.

COMPUTER EDUCATION: The Committee will oversee the Association's marketing activities for the AMA/GTE Medical Information Network; and as part of those activities will conduct programs to educate physicians on the applications of computers in the medical office.

William M. McClatchey, Atlanta, CHAIRMAN
Edward D. Biggerstaff, III, Savannah
Floyd P. Garrett, Atlanta
William M. Headley, Milledgeville
Jack F. Menendez, Macon
Richard C. Mattison, Atlanta
James A. Sullivan, Columbus
Alan D. Clark, Alpharetta
MAG Staff, Steve Davis

MEDICAL PRACTICE: To promote the private practice of medicine by evaluating changing health care patterns, including quality of care, access, and finance. The strengths and weaknesses of possible changes shall be evaluated and the possible impact of these changes on private health care explained to the membership. This committee shall also have responsibility for promoting liaison between physicians and hospitals.

W. Dan Jordan, Atlanta, CHAIRMAN
Jack H. Cohen, Atlanta
William Harper, Columbus
Mrs. George R. (Judy) Jones, Atlanta
Robert E. Kelley, Jr., Athens
Werner Linz, LaGrange
Thomas Schoberg, Atlanta
Howard Sigal, Smyrna
Charles E. Todd, Jr., Atlanta
Joseph S. Wilson, Atlanta
Asa G. Yancey, Atlanta
Neal F. Yeomans, Waycross
Michael Roberts, Albany
MAG Staff, Joyce Butler

MEDICINE & HUMAN VALUES: To provide information to the MAG membership about issues related to human values which affect medical practice; it will also suggest programs, activities, legislation, etc. which support the preservation of such values both in the medical profession and in the community as a whole.

Richard B. Stewart, Decatur, CHAIRMAN
William Weston, III, Augusta
Mary Anne T. Hagler, Augusta
Gary M. Harrison, Decatur
Fred Kratina, LaGrange
Martha J. McAnulty, Atlanta
Walker C. McGraw, Atlanta
Hans J. Peters, Columbus
Dent Purcell, Savannah
Mrs. W. Jack (Eldred) Smith, St. Simons Island
MAG Staff, Joyce Butler

MEMBERSHIP INSURANCE: The charge of this Committee shall be threefold. The Committee shall (1) objectively assess professional liability insurance carriers as to quality, availability, and cost of coverage; (2) provide courses on risk management for Georgia physicians; and (3) evaluate other general insurance coverage.

Kenneth L. Goldman, Columbus, CHAIRMAN
John T. Mauldin, Atlanta
William Hardcastle, Decatur
Ronald Roper, Marietta
J. Rhodes Haverty, Atlanta
Ralph Hopkins, Gainesville
William M. Headley, Milledgeville
William W. Moore, Jr., Atlanta
Richard C. Mattison, Decatur
William Amos, Columbus
Donald Chait, Atlanta
Thomas L. German, Savannah
MAG Staff, L. B. Storey

IMPAIRED PHYSICIANS: The Committee shall be responsible for overseeing the activities of the program in Georgia and the activities of the Physician's Consultant Committee in an effort to reach every physician in Georgia who is chemically dependent on drugs/alcohol, seeking their treatment and recovery. The Committee shall make timely reports on its activities and the direction in which the program is moving to the Council on Membership Services.

Edward Waits, Atlanta, CHAIRMAN
Olav H. Alvig, Cumming
Mrs. Margaret Clements, Atlanta
Robert Cunningham, Atlanta
David B. Dennison, Atlanta
Mikell B. Karsten, Tifton
Fred Kratina, LaGrange
S. Reaves Lee, Atlanta
Louis O. J. Manganiello, Augusta
E. M. (Mac) Molnar, Columbus
Walker C. McGraw, Atlanta
Dan C. Newberry, Columbus
R. J. Van de Wetering, Atlanta
Asa Yancey, Atlanta
Chairman of Physician Consultant Committee (Ex-officio)
MAG Staff, Jim Moffett

IMPAIRED PHYSICIAN CONSULTANT COMMITTEE: Shall administratively and operationally report to the Impaired Physicians Committee. Shall receive permission from the Impaired Physicians Committee to contact and involve all physicians in the Impaired Physicians Program; all correspondence to the Executive Committee of the Medical Association of Georgia, Georgia Hospital Administrators, Nursing Association of Georgia, Pharmacy Association of Georgia, etc., shall be sent initially to the Impaired Physicians Committee for transmittal; shall initiate contact with physicians reported to have alcohol, drug, or psychiatric problems for involvement in the Impaired Physicians Program; shall make repeated efforts to involve an impaired physician in the program — only after it fails, shall the Impaired Physicians Committee be notified and become involved; shall send two members from another geographic part of the State of Georgia to see an impaired physician initially and attempt to enlist him in the program; shall visit the doctor's home community, hospital, and hospital board or authority following completion of the program and periodically thereafter to help the physician in his reentry phase back into medical practice; membership of the committee shall be periodically expanded by addition of graduates of the Impaired Physicians Program; shall meet on a scheduled basis with the Impaired Physicians Committee to discuss the policy, problems, and individual cases of the Impaired Physicians Program.

G. Douglas Talbott, Smyrna, CHAIRMAN
Charles E. Bagley, Alma
Earl Benson, Marietta
Robert M. Boger, Decatur
A. W. Bramblett, Jr., Forsyth
Grover J. Brown, Cartersville
Iverson Bryans, Augusta
William G. Cutts, Jr., Canton
Bruce A. Elrod, Ft. Oglethorpe
F. Dempsey Guillebeau, Albany
Ralph Huie, Atlanta
Robert D. May, Marietta
William Patterson, Columbus
William D. Tumlin, Lexington
Robert J. Van de Wetering, Atlanta
John A. Wells, Macon
MAG Staff, Jim Moffett

COUNCIL ON LIAISON

Council Chairman: Ronald P. Roper, Marietta

CHARGE: Coordinating the Association's communication with other organizations in the health care field.

AUXILIARY: The Committee on Auxiliary shall cooperate with, advise, and direct the Auxiliary in all matters concerning the Association.

Robley D. Smith, Tifton, CHAIRMAN
S. William Clark, Jr., Waycross
Alva L. Mayes, Jr., Macon

Joe L. Nettles, Savannah
Dent W. Purcell, Savannah
James H. Sullivan, Columbus
Sammie Dixon, Tifton
MAG Staff, Talitha Russell

COMPOSITE STATE BOARD OF MEDICAL EXAMINERS: Established to provide exchange of information between the Composite State Board of Medical Examiners and MAG.

Charles E. Harrison, Jr., Atlanta, CHAIRMAN
Benjamin S. Anderson, Jr., Cedartown
Robert Copeland, LaGrange
John H. Deaton, Columbus
Julius T. Johnson, Augusta
William E. Mayher, III, Albany
LaMar S. McGinnis, Jr., Decatur
Wells Riley, Jonesboro
MAG Staff, Rusty Kidd

COST AWARENESS: Charged to study health care costs in an effort to control their rise without reducing the quality of care available to patients; to interact with similar committees at the hospital and county medical society levels in order to share information on controlling rising costs; monitor, interface with, and coordinate the activities of state, regional, and local coalitions with the business community and others; and to make recommendations to the Council on Liaison to establish MAG policy positions on controlling rising costs of health care.

Virgle McEver, Jr., Warner Robins, CHAIRMAN
Joe Almand, LaGrange
O. B. Carter, Jr., Albany
Louis Felder, Atlanta
Jack A. Raines, Columbus
Joe C. Stubbs, Valdosta
Charles R. Underwood, Marietta
MAG Staff, Hoyt Torras

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Kenneth Woodsides, Atlanta
MAG Staff, Bo Shurling

COMMITTEE ON NON-PHYSICIAN HEALTH CARE PROVIDERS: Established to maintain liaison with non-physician health care providers and their associations. The Committee will study and make recommendations on actions taken by or relating to non-physician health care professions which have an actual or potential impact on the practice of medicine. The Committee will propose ways in which MAG can cooperate in programs with other health care professions to promote the goals of MAG.

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PHYSICIAN-LAWYER LIAISON: Responsible for overseeing the interrelationships between physicians and lawyers and their respective state professional associations in Georgia. The Committee will attempt to promote better understanding and harmony between the two professions.

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T. O. Sturkie, Marietta
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SPECIALTY SOCIETY RELATIONS: The Committee shall maintain communication between MAG and the specialty societies.

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Thomas F. Smith, Allergy & Immunology Society of Georgia
Thomas L. Tidmore, Jr., Ga. Society of Anesthesiologists
Joseph I. Miller, Ga. Thoracic Society
William L. Dobes, Ga. Society of Dermatologists
Selwyn T. Hartley, Ga. Chapter, American College of Emergency Physicians
Terrell B. Tanner, Ga. Academy of Family Physicians
David E. Hein, Ga. Gastroenterologic Society
William C. Waters, III, Ga. Chapt. American College of Physicians
David E. Dalrymple, Ga. Society of Internal Medicine
Richard D. Franco, Ga. Neurological Society
John T. Godwin, Ga. Society of Nuclear Medicine
Samuel R. Poliakoff, Ga. State Obstetrical-Gynecological Society
John H. Reed, Ga. Society of Ophthalmology
Anthony Parke Avery, Ga. Society of Otolaryngology

Emmerich von Haam, Jr., Ga. Orthopaedic Society
Robert E. DeLashmutt, Ga. Association of Pathologists
David L. Morgan, Ga. Chapter American Academy of Pediatrics
E. A. Mussarra, II, Ga. Society of Plastic Surgeons
Joseph B. Baird, Jr., Ga. Psychiatric Association
William R. Elsea, Ga. Chapter, American Association of Public Health Physicians
Richard S. Colvin, Ga. Radiological Society
John A. Goldman, Ga. Rheumatism Society
John I. Dickinson, Ga. Chapter, American College of Surgeons
Thomas J. Florence, Ga. Urological Association
MAG Staff, Jim Moffett

THIRD PARTY PAYORS: Oversee the relationships between the Association and health insurors — both private and public. The Committee will help to provide a forum for discussion of issues between and among the Association and the insurors. The Committee will be responsible for investigating the insuror's basis of reimbursement, for methods of claims processing, and for the benefits packages available. The Committee will review federal and state health programs and make its findings available to the Association membership.

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COUNCIL ON PUBLIC RELATIONS

Council Chairman: Charles W. McDowell, Jr., Decatur

CHARGE: The Public Relations Council is to provide advice and assistance, upon request, to MAG committees, the Board of Directors, and the House of Delegates in communicating the Association's positions and policies to the public.
The Council is also charged with making recommendations as to the annual budget that will serve the best interests of the Association in relating to the public and is further charged as being the oversight committee for MAG's Public Relations Department.

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A.M.A. Ethics Code

Preamble

The medical profession has long subscribed to a body of ethical statements developed primarily for the benefits of the patient. As a member of this profession, a physician must recognize responsibility not only to patients, but also to society, to other health professionals, and to self. The following Principles adopted by the American Medical Association are not laws, but standards of conduct which define the essentials of honorable behavior for the physician.

1

A physician shall be dedicated to providing competent medical service with compassion and respect for human dignity.

2

A physician shall deal honestly with patients and colleagues, and strive to expose those physicians deficient in character or competence, or who engage in fraud or deception.

3

A physician shall respect the law and also recognize a responsibility to seek changes in those requirements which are contrary to the best interest of the patient.

4

A physician shall respect the rights of patients, of colleagues, and of other health professionals, and shall safeguard patient confidences within the constraints of the law.

5

A physician shall continue to study, apply and advance scientific knowledge, make relevant information available to patients, colleagues, and the public, obtain consultation, and use the talents of other health professionals when indicated.

6

A physician shall, in the provision of appropriate patient care, except in emergencies, be free to choose whom to serve, with whom to associate, and the environment in which to provide medical services.

7

A physician shall recognize a responsibility to participate in activities contributing to an improved community.

County Medical Society Duties and Responsibilities — A Review

THE RECENT CHANGE in elected leadership of the Association presents a logical opportunity to review obligations and responsibilities of both individuals and county medical societies to MAG. Problems continue to arise regarding the proper filing of applications, the timely submission of dues money to the Association, and the improper maintenance of county society constitutions and bylaws.

Listed below are items from the MAG Constitution and Bylaws that relate to these duties and responsibilities.

COUNTY SOCIETY ORGANIZATION

Charters

Component county societies are chartered by the MAG. Collectively, the component societies form the MAG.

Charters, outlining the duties and responsibilities of the county society, should be kept by the county society secretary, and a copy should also be on file at MAG headquarters.

Duties

Each society is required to meet at least four times per year and *must* elect officers and delegates before February 1. This information *must* be transmitted to MAG headquarters, also prior to February 1.

All county medical societies must develop and maintain constitutions and bylaws that are not in conflict with those of MAG. A copy of these documents should be on file at MAG headquarters.

Delegates

Representation in the MAG House of Delegates is based on one delegate and one alternate for each 25 county society members or fraction thereof who are members of MAG. The number of delegates is determined by the number of active dues-paying members and life (dues-exempt) members as of December 31 of the preceding year. Notification of properly elected delegates and alternates must be made to MAG headquarters by February 1.

In order to serve as a delegate or alternate, a member must have been a member in good standing in MAG for the *three years* preceding his election. Elected delegates and alternates who do not meet this qualification cannot be seated in the House. Also, a delegate's dues *must* be paid prior to Annual Session in order for them to be seated in the House.

Dues and Assessments

Dues are established by the House of Delegates upon recommendation of the Board of Directors.

County medical society secretaries are required to certify to the secretary of MAG on a date specified by the secretary the names of members of the society, their correct mailing addresses and the amount of dues and assessments for the next calendar year. This bylaws' requirement is essential for the orderly administration of Association membership business.

Members' dues must be submitted by April 1. If not submitted by this date the member will be suspended, as will all member services until *all* dues have been paid.

It is most important that all counties not on MAG central billing report dues collections as soon as they are received.

Any physician, duly qualified, who wishes to transfer membership from another state to MAG may do so without payment of MAG dues for the year in which he transfers if the physician is dues paid for the current year in the Association from which he transfers. If an MAG member moves from one county to another, he should advise the Association of this change and complete a county medical society transfer form.

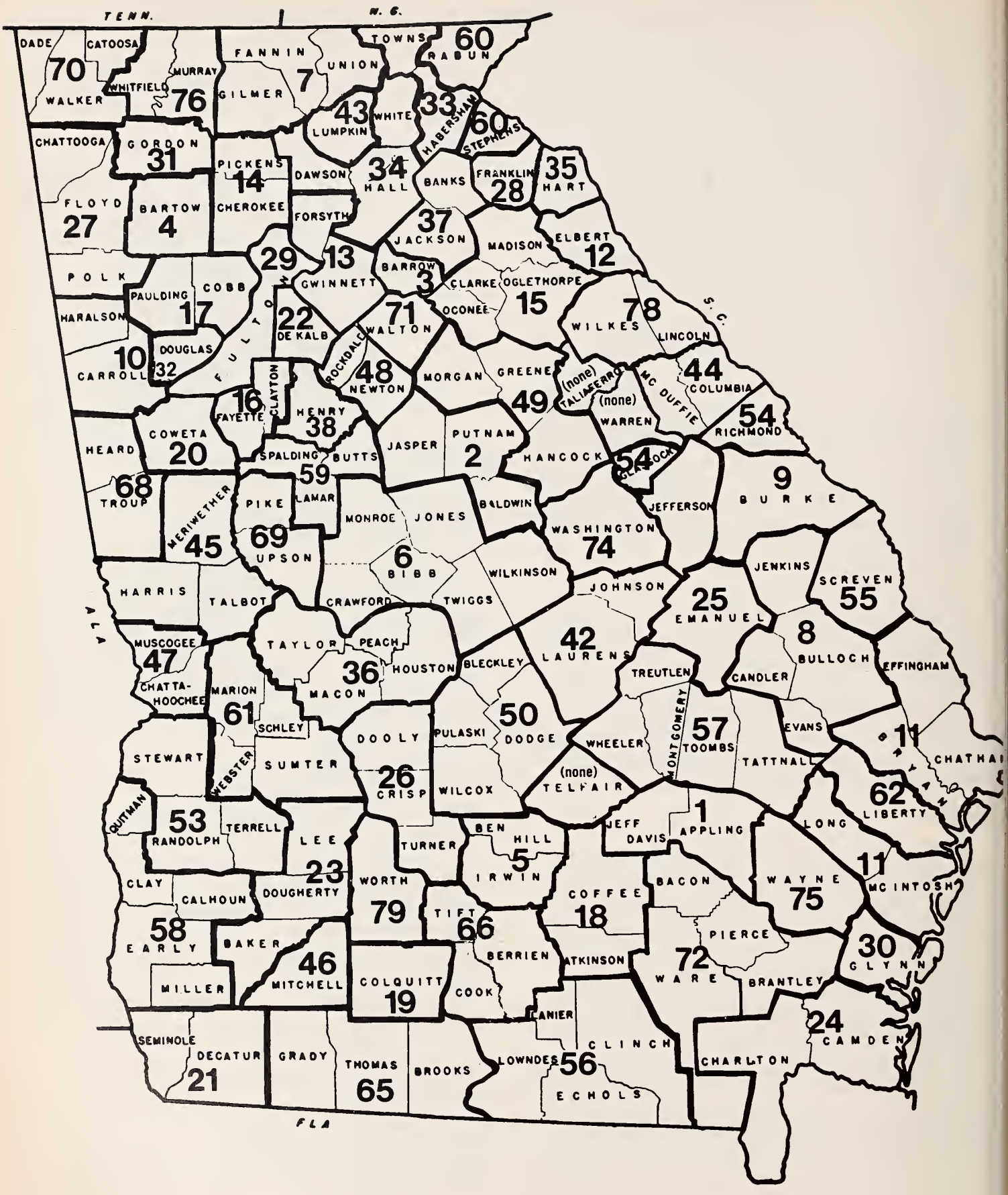
Dues-Exempt Membership

The one dues-exempt classification that is most often misunderstood is that of the life membership.

In order to qualify in this category a member must have reached his 70th birthday and have completed 25 years continuous active membership in MAG. A member may also qualify by being a member of MAG for 10 years with the balance being served in another state association.

Life memberships have caused confusion primarily because some county society requirements are different from MAG's. This category of membership must be certified through the Association to insure eligibility.

All members, particularly those in leadership positions, should acquaint themselves with the various sections of the MAG Constitution and Bylaws.



County Medical Societies

COUNTY GUIDE LIST

The following County Guide List is provided as an aid in locating a specific member physician. The first column lists the county in which he practices; the second column indicates the number of the component county medical society in which he holds membership; the third column is the name of the component county medical society; and the fourth column gives the page number on which each component county listing begins.

County	County No.	County Medical Society	Page Number
Appling	1	Altamaha	52
Atkinson	18	Coffee	64
Bacon	72	Ware	99
Baldwin	2	Baldwin	52
Baker	23	Dougherty	68
Banks	37	Jackson-Banks	86
Barrow	3	Barrow	52
Bartow	4	Bartow	52
Ben Hill	5	Ben Hill-Irwin	52
Berrien	66	Tift	97
Bibb	6	Bibb	52
Bleckley	50	Ocmulgee	90
Brantley	72	Ware	99
Brooks	65	Thomas Area	97
Bryan	11	Georgia Medical Society	56
Bulloch	8	Ogeechee River	55
Burke	9	Burke	55
Butts	59	Spalding	95
Calhoun	58	Southwest Georgia	95
Camden	24	Camden-Charlton	69
Candler	8	Ogeechee River	55
Carroll	10	Carroll-Haralson	56
Catoosa	70	Walker-Catoosa-Dade	98
Charlton	24	Camden-Charlton	69
Chatham	11	Georgia Medical Society	56
Chattahoochee	47	Muscogee	88
Chattooga	27	Floyd-Polk-Chattooga	69
Cherokee	14	Cherokee-Pickens	59
Clarke	15	Crawford W. Long	59
Clay	58	Southwest Georgia	95
Clayton	16	Clayton-Fayette	60
Clinch	56	South Georgia	94
Cobb	17	Cobb	61
Coffee	18	Coffee	64
Colquitt	19	Colquitt	64
Columbia	44	McDuffie	87
Cook	66	Tift	97
Coweta	20	Coweta	64
Crawford	6	Bibb	52
Crisp	26	Flint	69
Dade	70	Walker-Catoosa-Dade	98
Dawson	34	Hall	85
Decatur	21	Decatur-Seminole	65
DeKalb	22	DeKalb	65
Dodge	50	Ocmulgee	90
Dooly	26	Flint	69
Dougherty	23	Dougherty	68
Douglas	32	Douglas	84
Early	58	Southwest Georgia	95
Echols	56	South Georgia	94
Effingham	11	Georgia Medical Society	56
Elbert	12	Elbert	58
Emanuel	25	Emanuel	69
Evans	8	Ogeechee River	55
Fannin	7	Blue Ridge	55
Fayette	16	Clayton-Fayette	60
Floyd	27	Floyd-Polk-Chattooga	69
Forsyth	13	Gwinnett-Forsyth	58
Franklin	28	Franklin	70
Fulton	29	Medical Assoc. of Atlanta	70
Gilmer	7	Blue Ridge	55
Glascock	54	Richmond	90
Glynn	30	Glynn	83
Gordon	31	Gordon	84
Grady	65	Thomas Area	97
Greene	49	Oconee Valley	90
Gwinnett	13	Gwinnett-Forsyth	58
Habersham	33	Habersham	85
Hall	34	Hall	85
Hancock	49	Oconee Valley	90
Haralson	10	Carroll-Haralson	56
Harris	45	Meriwether-Harris-Talbot	87
Hart	35	Hart	86
Heard	68	Troup	98
Henry	38	Henry	87
Houston	36	Peach Belt	86
Irwin	5	Ben Hill-Irwin	52
Jackson	37	Jackson-Banks	86
Jasper	2	Baldwin	52
Jeff Davis	1	Altamaha	52
Jefferson	39	Jefferson	87
Jenkins	8	Ogeechee River	55
Johnson	42	Laurens	87
Jones	6	Bibb	52
Lamar	59	Spalding	95
Lanier	56	South Georgia	94
Laurens	42	Laurens	87
Lee	23	Dougherty	68
Liberty	62	St. John's Parish	96
Lincoln	78	Wilkes	100
Long	11	Georgia Medical Society	56
Lowndes	56	South Georgia	94
Lumpkin	43	Lumpkin	87
McDuffie	44	McDuffie	87
McIntosh	11	Georgia Medical Society	56
Macon	36	Peach Belt	86
Madison	15	Crawford W. Long	59
Marion	61	Sumter	96
Meriwether	45	Meriwether-Harris-Talbot	87
Miller	58	Southwest Georgia	95
Mitchell	46	Mitchell	87
Monroe	6	Bibb	52
Montgomery	58	Southeast Georgia	95
Morgan	49	Oconee Valley	90
Murray	76	Whitfield-Murray	100
Muscogee	47	Muscogee	88
Newton	48	Newton-Rockdale	90
Oconee	15	Crawford W. Long	59
Oglethorpe	15	Crawford W. Long	59
Paulding	17	Cobb	61
Peach	36	Peach Belt	86
Pickens	14	Cherokee-Pickens	59
Pierce	72	Ware	99
Pike	69	Upson	98
Polk	27	Floyd-Polk-Chattooga	69
Pulaski	50	Ocmulgee	90
Putnam	2	Baldwin	52
Quitman	58	Southwest Georgia	95
Rabun	60	Stephens-Rabun	96
Randolph	53	Randolph-Stewart-Terrell	90
Richmond	54	Richmond	90
Rockdale	48	Newton-Rockdale	90
Schley	61	Sumter	96
Screven	55	Screven	94
Seminole	21	Decatur-Seminole	65
Spalding	59	Spalding	95
Stephens	60	Stephens-Rabun	96
Stewart	53	Randolph-Stewart-Terrell	90

County	County No.	County Medical Society	Page Number
Sumter	61	Sumter	96
Talbot	45	Meriwether-Harris-Talbot	87
Taliaferro		No Society	
Tattnall	57	Southeast Georgia	95
Taylor	36	Peach Belt	86
Telfair		No Society	
Terrell	53	Randolph-Stewart-Terrell	90
Thomas	65	Thomas Area	97
Tift	66	Tift	97
Toombs	57	Southeast Georgia	95
Towns	33	Habersham	85
Treutlen	57	Southeast Georgia	95
Troup	68	Troup	98
Turner	26	Flint	69
Twiggs	6	Bibb	52
Union	7	Blue Ridge	55
Upson	69	Upson	98
Walker	70	Walker-Catoosa-Dade	98
Walton	71	Walton	99
Ware	72	Ware	99
Warren		No Society	
Washington	74	Washington	100
Wayne	75	Wayne	100
Webster	61	Sumter	96
Wheeler	57	Southeast Georgia	95
White	34	Hall	85
Whitfield	76	Whitfield-Murray	100
Wilcox	50	Ocmulgee	90
Wilkes	78	Wilkes	100
Wilkinson	6	Bibb	52
Worth	79	Worth	100

County Society Officers

1. **Altamaha**
   Pres: P. K. Batra, 204 E. Tollison St, Baxley 31513,(912) 367-7044
   Secy: B. S. Patel, 210 E. Tollison St, Baxley 31513, (912) 367-6644
2. **Baldwin**
   Pres: Jose A. Delgado, 511 N. Cobb St, Milledgeville 31061, (912) 452-6476
   Secy: Abelardo Delgado, Central State Hosp., Box 42, Milledgeville 31061
3. **Barrow**
   Pres: Hugh O. Hodges, 330 Highland Dr, Winder 30680, (404) 867-9186
   Secy: Joe C. Souther, 802 East Ave, Winder 30680, (404) 867-9181
4. **Bartow**
   Pres: Grover Brown, P.O. Box 908, Cartersville 30120, (404) 382-7446
5. **Ben Hill-Irwin**
   Pres: C. Morgan Smith, Box 338, Fitzgerald 31750, (912) 423-4384
   Secy: William J. Hammond, P.O. Box 929, Fitzgerald 31758, (912) 423-2058
6. **Bibb**
   Exec Sec: Kyla K. Connor, 770 Pine St, #150, Macon 31201, (912) 743-5215
   Pres: Rodney M. Browne, 380 Hospital Dr, Macon 31201, (912) 743-4646
   Secy: William P. Brooks, 3741 Houston Ave, Macon 31201, (912) 781-2992
7. **Blue Ridge**
   Pres: E. J. Fernandez, P. O. Box 587, Ellijay 30540, (404) 632-3211
   Secy: Robert A. Burns, P. O. Box 725, Blue Ridge 30513, (404) 632-5212
8. **Ogeechee River**
   Pres: William Deal, P. O. Box 647, Donehoo St, Statesboro 30458, (912) 764-5657
   Secy: Don R. Connell, 500 E. Grady St, Statesboro 30458, (912) 764-6671
9. **Burke**
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   Secy: Shelley Griffin, 304 Jones Ave, Waynesboro 30830, (404) 554-5147
10. **Carroll-Haralson**
    Pres: Ralph Fleck, 148 Clinic Ave, Carrollton 30117
    Secy: Charles N. Hubbard, 148 Clinic Ave, Carrollton 30117, (404) 834-0873
11. **Georgia Medical Society**
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    Pres: Robert Quattlebaum, Jr., 5354 Reynolds St, Savannah 31405, (912) 356-1000
    Secy: Roderick L. Guerry, P. O. Box 9787, Savannah 31402, (912) 356-6202
12. **Elbert**
    Pres: Glen Poon, 33 Chestnut St, Elberton 30635, (404) 283-3315
    Secy: Jack B. Hanks, 33 Chestnut St, Elberton 30635, (404) 283-3315
13. **Gwinnett-Forsyth**
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    Secy: Rupert Bramblett, 326 Dahlonega St, Cumming 30130, (404) 887-5055
14. **Cherokee-Pickens**
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    Secy: David R. Collins, 110 Waleska Rd, Canton 30114, (404) 479-1815
15. **Crawford W. Long**
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    Pres: Ronald P. Rober, 823 Campbell Hill St, #210, Marietta 30060, (404) 428-4413
    Secy: John G. Roberts, 1790 Mulkey Rd, Ste 8-A, Austell 30001, (404) 944-1830
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    Secy: K. Arunachalem, P. O. Box 1409, Douglas 31533
19. **Colquitt**
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    Secy: Michael H. Whittle, P. O. Box 608, Moultrie 31768, (912) 985-8802

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Pres: Frederick E. Gilbert, Jr., P. O. Box 1301, Newnan 30264
Secy: James M. Eaton, Jr., Papp Clinic, 15 Cavender St, Newnan 30263, (404) 253-6616

21. Decatur-Seminole
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22. DeKalb
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Pres: William J. Rawls, 755 Columbia Dr, Ste. 912, Decatur 30030
Secy: Roy W. Vandiver, 370 Winn Way, #201, Decatur 30030, (404) 292-4612

23. Dougherty
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Pres: Harry N. Dorsey, 910 N. Jefferson, Albany 31701, (912) 888-0898
Secy: A. Frank Isele, P. O. Box 1908, Albany 31703, (912) 432-8108

24. Camden-Charlton
Pres: Willis R. Keene, 1001 N. 3rd St, Folkston 31537, (912) 496-7317
Secy: Ramon V. Alvarez, P. O. Drawer 170, St. Mary's 31558, (912) 882-4374

25. Emanuel
Pres: Carter L. Meadows, P. O. Box 879, Swainsboro 30401
Secy: Chang Kue Kim, P. O. Box 7, Swainsboro 30401, (912) 237-6955

26. Flint
Pres: George Wagner, 416-B E. 4th Ave, Cordele 31015
Secy: David DuVall, 416-B E. 4th Ave, Cordele 31015

27. Floyd-Polk-Chattooga
Exec Sec: Cathy Higgins, 102 Saddle Mountain Rd, Rome 30161, (404) 295-7703
Pres: Joel Todino, 11 John Maddox Dr, Rome 30171, (404) 295-3961
Secy: Suzanne G. Pratt, 909 N. 5th Ave, Rome 30161, (404) 291-2144

28. Franklin
Pres: Wesley W. Harris, 350 Church St, Royston 30662, (404) 245-6177
Secy: Hoyt Crump, 350 Church St, Royston 30662, (404) 245-6177

29. Medical Association of Atlanta (General information (404) 881-1714)
Exec Sec: John F. Kiser, 875 W. Peachtree St, NE, Atlanta 30309, (404) 881-1020
Pres: Jeffrey T. Nugent, 875 W. Peachtree St, NE, Atlanta 30309, (404) 881-1020
Secy: Steven L. Sanders, 875 W. Peachtree St, NE, Atlanta 30309, (404) 881-1020

30. Glynn
Pres: W. Lynn Hicks, Glynn Emergency Clinic, Brunswick 31521, (912) 267-7600
Secy: Edwin A. Mayo, 3215 Shrine Rd, Brunswick 31520, (912) 267-1960

31. Gordon
Pres: Morris L. Jenkins, Box 125, Calhoun 30701
Secy: Frank Alvarez, 916 S. Wall St, P. O. Box 400, Calhoun 30701, (404) 629-9878

32. Douglas
Pres: J. Gordon Barrow, Ste. 110-B, 8954 Hospital Dr, Douglasville 30134, (404) 949-2794
Secy: James D. Hull, 8954 Hospital Dr, #105-C Douglasville, 30134, (404) 949-0700

33. Habersham
Pres: L. G. Hicks, Jr., Madison St, Clarkesville 30523, (404) 754-4124

34. Hall
Exec Sec: Mary J. Keith, P. O. Box 2684, Gainesville 30503, (404) 536-7122
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Secy: Samuel D. Rauch, 710 Broad St, Gainesville 30501, (404) 532-9864

35. Hart
Pres: L. G. Cacchioli, 202 W. Howell St, Hartwell 30643, (404) 376-5111
Secy: Billy J. Davis, Gibson St, Hartwell 30643

36. Peach Belt
Pres: J. W. Spivey, 124 Hospital Dr, Warner Robins 31903, (912) 923-0153
Secy: J. Q. Whitaker, P. O. Box 2343, Warner Robins 31093, (912) 929-1726

37. Jackson-Banks
Pres: Sam Vickery, 259 N. Elm St, Commerce 30529, (404) 335-5114
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38. Henry
Secy: Gustavo Escalera, Henry Prof. Bldg., #9, Stockbridge 30281, (404) 474-7287

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Secy: Duren Daniell, 112 Rowe St, Dublin 31021

43. Lumpkin
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Secy: James S. Harvey, 403 Hawkins St., Dahlonega 30533, (404) 864-3319

44. McDuffie
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Secy: Michael Powell, 604 Ware St, Thomson 30824, (404) 595-6824

45. Meriwether-Harris-Talbot
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46. Mitchell
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47. Muscogee
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48. Newton-Rockdale
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50. Ocmulgee
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Secy: Jack A. Butler, Unadilla Prof., Bldg., P. O. Box 666, Unadilla 31091

53. Randolph-Stewart-Terrell
Pres: Thomas M. Allen, Johnson St, P. O. Box 482, Dawson 31742
Secy: Emilio Delgado, 303 Johnson St, Dawson 31742

54. Richmond
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Pres: W. E. Barfield, Sr., 1500 Johns Rd, Augusta 30904, (404) 733-1225
Secy: Theodora Vanderzalm, Radiology Dept., MCG, Augusta 30912, (404) 828-2439

55. Screven
Pres: William R. Kent, Jr., P. O. Box 218, Sylvania 30467, (912) 564-2770

56. South Georgia
Pres: William A. Dickson, P. O. Box 608, Hahira 31632, (912) 794-3350
Secy: Frank Corker, 2704 N. Oak St, Bldg. N, Valdosta 31601, (912) 247-9911

57. Southeast Georgia
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Secy: Ben Barnard, 306 Maple Dr, Vidalia 30474

58. Southwest Georgia
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Secy: Virendra Saxena, P. O. Box 54, Fort Gaines 31751, (912) 768-2322

59. Spalding
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Secy: James Day, 231 Graefe St, Griffin 30223, (404) 227-1587

60. Stephens-Rabun
Executive Office Address: Stephen-Rabun CMS, P. O. Box 1521, Toccoa 30577
Pres: Robert W. Slate, Falls Rd, Prof. Park, Toccoa 30577, (404) 886-7408
Secy: Greg Varnadore, 497 Falls Rd, Toccoa 30577, (404) 886-7555

61. Sumter
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62. St. John's Parish
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Secy: Glenn Carter, 303 Fraser Dr, Hinesville 31313, (912) 876-6101

65. Thomas Area
Pres: William Z. Bridges, 612 S. Broad St, Thomasville 31792, (912) 226-9211
Secy: W. A. Lardin, Archbold Mem. Hosp., Thomasville 31792, (912) 228-2766

66. Tift
Pres: Richard McCullough, 712 E. 18th St, Tifton 31794, (912) 382-3814
Secy: Clay Dorminey, 1409-B Tift Ave, Tifton 31794, (912) 382-3720

68. Troup
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Secy: Marc Hinrichs, 210 Battle St, LaGrange 30240, (404) 884-2371

69. Upson
Pres: Wayne Dodgen, 212 Cheorkee Rd, Thomaston 30286, (912) 647-1801
Secy: W. M. Dallas, 405 W. Main St, Thomaston 30286

70. Walker-Catoosa-Dade
Pres: Richard Smith, 508 S. Main St, P. O. Box 967, LaFayette 30728, (404) 638-1606
Secy: Edwin T. Hulse, 1 Thomas Rd, Ft. Oglethorpe 30742, (404) 861-1127

71. Walton
Pres: J. Donald James, Walton Clinic, Monroe 30655, (404) 267-6536

72. Ware
Pres: Michael O'Connell, 2507 Alice St, Waycross 31501, (912) 285-7830
Secy: John Rutledge, 2005-D Pioneer St, Waycross 31501, (912) 285-5230

74. Washington
Pres: William Rawlings, Sr., 522 Washington Ave, Sandersville 31082, (912) 522-6051
Secy: John R. Ward, 522 Washington Ave, Sandersville 31082, (912) 522-6051

75. Wayne
Pres & Secy: Ollie O. McGahee, Jr., P. O. Box 937, Jesup 31545, (912) 427-6964

76. Whitfield-Murray
Pres: William H. Lumpkin, 1 Starr Dr, Dalton 30720, (404) 278-0351
Secy: James C. Blackwell, 1308 Memorial Dr, Dalton 30720, (404) 226-3139

78. Wilkes
Pres: Charles E. Wills, Jr., 119 Gordon St, Washington 30673, (404) 678-2181

79. Worth
Pres: H. G. Davis, Jr., P. O. Box 405, Sylvester 31791, (912) 776-2141
Secy: H. O. Eason, Jr., 501 Westberry St, Sylvester 31791, (912) 776-3441


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Americus
Columbus
Athens
Augusta
Savannah
Thomasville
Valdosta
Fitzgerald
Dublin
Milledgeville
Cordele
Douglas
Waycross
Brunswick
St. Simons Island
Kingsland
St. Marys
Folkston
Hazlehurst
Swainsboro
Statesboro
Millen
Sylvania
Vidalia
Lyons
Claxton
Metter
Reidsville
Pembroke
Hinesville
Darien
Jesup
Blackshear
Nahunta
Alma
Douglas
Nashville
Ocilla
Tifton
Moultrie
Thomasville
Bainbridge
Cairo
Donalsonville
Colquitt
Camilla
Leesburg
Albany
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Ashburn
Fitzgerald
Irwinton
Dublin
Louisville
Wrightsville
Sandersville
Tennille
Deepstep
Davisboro
Harlem
Grovetown
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Peachtree City
Tyrone
Senoia
Newnan
Raymond
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Turin
Sargent
Griffin
Experiment
Gordon
Milner
Barnesville
Zebulon
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Molena
Thomaston
East Thomaston
Culloden
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Junction City
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District	President	Secretary
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3	V. W. McEver, Jr. 105-B Briarcliff, Warner Robins 31093, (912) 923-0144	George R. Brahn 105-B Briarcliff, Warner Robins 31093, (912) 923-0144
4*	William J. Rawls 755 Columbia Dr, Ste 912, Decatur 30030, (404) 373-3103	Roy W. Vandiver 370 Winn Way, Ste 201, Decatur 30030, (404) 292-4612
5†	Jeffrey T. Nugent 875 W. Peachtree St, NE, Atlanta 30309, (404) 881-1020	Steven L. Sanders 875 W. Peachtree St, NE, Atlanta 30309, (404) 881-1020
6	A. Glenn Bailey 303 Smith St, LaGrange 30240, (404) 882-8831	Ralph P. Warnock 208 Cherokee Rd, Thomaston 30286, (404) 647-8901
7	Donald R. Thomas 1714 Cleveland Rd, Dalton 30720, (404) 259-9781	Ed Brewster, Jr. 1104 Martha Berry Blvd, Rome 30161, (404) 291-2077
8	Owen K. Youles, Jr. Doctors Bldg, Valdosta 31601, (912) 242-7775	Neal F. Yeomans P.O. Box 938, Waycross 31601, (912) 283-4363
9	Joe L. Griffeth Medical Center Clinic, Commerce 30529, (404) 335-5155	Rodney L. Smith Northeast Georgia Medical Center, 743 Spring St, Gainesville 30505, (404) 534-2809
10	Vacant	A. Delone Muse, Jr. 740 Prince Ave, Athens 30601

* *DeKalb Medical Society*
† *Medical Association of Atlanta*

Specialty Society Officers

ALLERGY AND IMMUNOLOGY

Allergy and Immunology Society of Georgia
Pres: Stanley F. Fineman, 833 Campbell Hill St, #490, Marietta 30060
Secy: David D. Tanner, 1938 Peachtree St, NW, Ste 507, Atlanta 30309

ANESTHESIOLOGY

Georgia Society of Anesthesiologists
Pres: Guy C. Davis, Jr., 1671 Council Bluff Dr, NE, Atlanta 30345
Secy: William Hammonds, Dept. of Anesthesia, Emory Univ. Hosp., 1365 Clifton Rd, NE, Atlanta 30322

CHEST DISEASE

Georgia Thoracic Society
Pres: C. Neil Kelley, 710 Broad St, SE, Gainesville 30501
Secy: Gilbert Grossman, 25 Prescott St, NE, Atlanta 30308

Georgia Chapter, American College of Chest Physicians
Pres: Walter Dunbar, 384 Peachtree St, NE, Atlanta 30308
Secy: Robert J. DiBenedetto, P. O. Box 22069, Savannah 31403
Exec Officer: Ed Kramer, American Lung Assn., Ga. Div., 2452 Spring Rd, Smyrna 30080

DERMATOLOGY

Georgia Society of Dermatologists
Pres: J. Tom Apgar, 1462 Montreal Rd, Ste 203, Tucker 30084
Secy: Gerald Chotimer, 3250 Howell Mill Rd, NW, Ste 201, Atlanta 30327

EMERGENCY MEDICINE

Georgia Chapter, American College of Emergency Physicians
Pres: Frederick B. Cowen, 2945 N. Druid Hills Rd, NE, Atlanta 30329
Secy: Selwyn Hartley, 33 SW Upper Riverdale Rd, Ste 101, Riverdale 30274

FAMILY PRACTICE

Georgia Academy of Family Physicians
Pres: John E. Fowler, GAFP, Ste 205, 11 Corporate Sq, Atlanta 30329
Secy: Ernest J. Jones, GAFP, Ste 205, 11 Corporate Sq, Atlanta 30329
Exec Vice Pres: Camille L. Day, 11 Corporate Sq, Ste 205, Atlanta 30329

GASTROENTEROLOGY

Georgia Gastroenterologic Society
Pres: Paul J. Rodzewicz, 5669 Peachtree-Dunwoody Rd, Atlanta 30342
Secy-Treas: Henry M. Middleton, VA Medical Center, Augusta 30910

INTERNAL MEDICINE

Georgia Chapter, American College of Physicians
Governor: Malcolm Page, Medical College of Georgia, Augusta 30912
Georgia Society of Internal Medicine
Pres: Richard E. DuBois, 478 Peachtree St, NE, Atlanta 30308
Sec-Treas: Norman I. Goldman, 909 Center St, Columbus 31901
Exec Director: J. Tom Sawyer, MAG, 938 Peachtree St, NE, Atlanta 30309

NEUROLOGY

Georgia Neurological Society
Pres: George G. B. Bilsten, 35 Collier Rd, NW, Atlanta 30309
Secy-Treas: Robert W. Gilbert, Ste 2020, 105 Collier Rd, Atlanta 30309

NEUROSURGERY

Georgia Neurosurgical Society
Pres: Joseph Barnett, 776 Canton Rd, Marietta 30066
Secy-Treas: James P. Ferguson, Harbin Clinic, 1825 Martha Berry Blvd, Rome 30161

NUCLEAR MEDICINE

Georgia Society of Nuclear Medicine
Pres: John D. Watson, Jr., Radiology Assoc. of Col., P. O. Box 2787, Columbus 31994
Secy: Oliver Sorsdahl, 300 Blvd, NE, Atlanta 30312

OB-GYN

Georgia State Obstetrical-Gynecological Society
Pres: Ralph A. Tillman, 5040 Snapfinger Woods Dr, Ste 204, Decatur 30035
Secy-Treas: Murray Freedman, 7 Retreat Rd, Augusta 30909
Exec Secy: Chester C. Lane, 69 Butler St, SE, Atlanta 30303

OPHTHALMOLOGY

Georgia Society of Ophthalmology
Pres: Irwin T. Staley, 653 Cherokee St, Marietta 30090
Secy-Treas: J. Donald Fite, #C-120, 500 Irvin Ct, Decatur 30030
Exec Secy: Talitha M. Russell, MAG, 938 Peachtree St, NE, Atlanta 30309

ORTHOPAEDICS

Georgia Orthopaedic Society
Pres: Paul Payne, 652 Church St, Marietta 30060
Secy-Treas: William C. Collins, 993 Johnson Ferry Rd, NE, Ste 100, Atlanta 30342

OTOLARYNGOLOGY

Georgia Society of Otolaryngology — Head and Neck Surgery
Pres: Warren L. Griffin, 800 First St, Macon 31201
Secy: Walter Ligon, 444 Fairground St, NE, Marietta 30062

PATHOLOGY

Georgia Association of Pathologists
Pres: A. Bleakely Chandler, Medical College of Georgia, Augusta 30912
Secy-Treas: Michael D. Stargel, St. Joseph's Hosp., 5665 Peachtree-Dunwoody Rd, NE, Atlanta 30342

PEDIATRICS

Georgia Chapter, American Academy of Pediatrics
Pres: Oscar S. Spivey, 2009 Vineville Ave, Macon 31204
Secy: Joseph V. Morrison, Jr., #4 Medical Arts Ctr, Savannah 31405
Exec Secy: William C. Mankin, 4059 Land-O-Lakes Dr, NE, Atlanta 30342

PLASTIC SURGERY

Georgia Society of Plastic Surgeons
Pres: John M. Griffin, Northwest Medical Ctr, 3280 Howell Mill Rd, NW, Ste 111, Atlanta 30327
Secy: Kenna Given, MCG, Section of Plastic Surgery, Augusta 30912

PSYCHIATRY

Georgia Psychiatric Association
Pres: Bernard C. Holland, Emory Univ. School of Med., P. O. Box AF, Atlanta 30322
Secy: DeWitt C. Alfred, Jr., Dept. of Psychiatry, E-814, Grady Hosp., 80 Butler St, SE, Atlanta 30335
Exec: J. Tom Sawyer, MAG, 938 Peachtree St, NE, Atlanta 30309

PUBLIC HEALTH

Georgia Chapter, American Association of Public Health Physicians
Pres: William R. Elsea, Fulton Co. Health Dept., 99 Butler St, SE, Atlanta 30303
Secy-Treas: Gunar N. Bohan, DeKalb Co. Health Dept., 440 Winn Way, Decatur 30030

RADIOLOGY

Georgia Radiological Society
Pres: Robert D. Waller, P. O. Box 687, Albany 31702
Secy: William C. Acton, 380 Hospital Dr, Macon 31201
Exec: J. Tom Sawyer, MAG, 938 Peachtree St, NE, Atlanta 30309

RHEUMATISM

Georgia Rheumatism Society
Pres: John Vansant, #A-1 St. Francis Med. Pk., 2300 Manchester Expressway, Columbus 31904
Secy: Sandy B. Carter, Jr., 1938 Peachtree St, NW, Atlanta 30309
Exec Director: Phil Bonner, Arthritis Foundation, Ga. Chapter, Inc., 2799 Delk Rd, SE, Marietta 30067

SURGERY

Georgia Chapter, American College of Surgeons
Pres: Fleming Jolley, 3216 Shrine Rd, Brunswick 31520
Secy-Treas: LaMar S. McGinnis, 365 Winn Way, Ste 201, Decatur 30030
Georgia Surgical Society
Pres: J. W. Veatch, Jr., 25 Prescott St, NE, Ste 5433, Atlanta 30308
Secy-Treas: William C. McGarity, Emory Univ. Clinic, 1365 Clifton Rd, NE, Atlanta 30322

UROLOGY

Georgia Urological Association
Pres: Ronald Roper, 823 Campbell Hill St, Marietta 30060
Secy-Treas: Richard Estes, 35 Collier Rd, NW, Ste 700, Atlanta 30309

Interspecialty Council Representatives

ALLERGY AND IMMUNOLOGY	**Allergy and Immunology Society of Georgia** Thomas F. Smith, Dept. of Pediatrics, 69 Butler St, SE, Atlanta 30303
ANESTHESIOLOGY	**Georgia Society of Anesthesiologists** Thomas L. Tidmore, Jr., 1405 Clifton Rd, NE, Atlanta 30322
CHEST DISEASE	**Georgia Thoracic Society** Joseph I. Miller, 1365 Clifton Rd, NE, Atlanta 30322
DERMATOLOGY	**Georgia Society of Dermatologists** William L. Dobes, 478 Peachtree St, NE, Ste 915-A, Atlanta 30308
EMERGENCY MEDICINE	**Georgia Chapter, American College of Emergency Physicians** Selwyn T. Hartley, 33 SW Upper Riverdale Rd, Riverdale 30274
FAMILY PRACTICE	**Georgia Academy of Family Physicians** Terrell B. Tanner, 110 Clarke St, Box C, Oxford 30267
GASTROENTEROLOGY	**Georgia Gastroenterologic Society** David E. Hein, 340 Boulevard, NE, Atlanta 30312
INTERNAL MEDICINE	**Georgia Chapter, American College of Physicians** William C. Waters, III, 35 Collier Rd, NW, Atlanta 30309 **Georgia Society of Internal Medicine** David E. Dalrymple, 6500 Vernon Woods Dr, NE, Atlanta 30328
NEUROLOGY	**Georgia Neurological Society** Richard D. Franco, 25 Prescott St, NE, Atlanta 30308
NEUROSURGERY	**Georgia Neurosurgical Society** Ellis B. Keener, 434 Academy St, Gainesville 30501
NUCLEAR MEDICINE	**Georgia Society of Nuclear Medicine** John T. Godwin, 4691 Sentinel Post Rd, NW, Atlanta 30327
OB-GYN	**Georgia State Obstetrical-Gynecological Society** Samuel R. Poliakoff, 105 Collier Rd, NW, Atlanta 30309
OPHTHALMOLOGY	**Georgia Society of Ophthalmology** John H. Reed, 1128 Vine St, NE, Gainesville 30501
OTOLARYNOGOLOGY	**Georgia Society of Otolaryngology — Head and Neck Surgery** Anthony Parke Avery, 316 W. 10th St, Rome 30161
ORTHOPAEDICS	**Georgia Orthopaedic Society** Emmerich von Haam, Jr., 1788 Bayard St, East Point 30344
PATHOLOGY	**Georgia Association of Pathologists** Robert E. Delashmutt, 340 Boulevard, NE, Atlanta 30312
PEDIATRICS	**Georgia Chapter, American Academy of Pediatrics** David L. Morgan, 1901 Century Boulevard, NE, Atlanta 30345
PLASTIC SURGERY	**Georgia Society of Plastic Surgeons** E. A. Mussarra, II, 114 Cherry St, Marietta 30060
PSYCHIATRY	**Georgia Psychiatric Association** Joseph B. Baird, Jr., 1970 Cliff Valley Way, NE, Atlanta 30329
PUBLIC HEALTH	**Georgia Chapter, American Association of Public Health Physicians** William R. Elsea, Fulton County Health Dept., 99 Butler St, SE, Atlanta 30303
RADIOLOGY	**Georgia Radiological Society** Richard S. Colvin, 1365 Clifton Rd, NE, Atlanta 30322
RHEUMATOLOGY	**Georgia Rheumatism Society** John A. Goldman, 960 Johnson Ferry Rd, Ste 340, Atlanta 30342
SURGERY	**Georgia Chapter, American College of Surgeons** John I. Dickinson, 310 W. Sixth St, Rome 30161
UROLOGY	**Georgia Urological Association** Thomas J. Florence, 2550 Windy Hill Rd, Ste 204, Marietta 30067
MAG BOARD OF DIRECTORS	Charles R. Underwood, 641 Church St, Marietta 30060

Explanation of Roster Information

This Roster is made up of physicians whose names were forwarded to the Headquarters Office of the Medical Association of Georgia by the secretaries of the component county medical societies as being members in good standing as of May 31, 1984. Consult the county society secretary concerning omissions.

This Roster contains two types of lists of the membership: the first is alphabetical, and the second is by county medical society. In each, the following information is given: name, county medical society number, membership status, specialty and subspecialty on the first line; address on the second line. All city names not followed by a state name are in Georgia. The County Guide List on page N lists each county, the number and name of the county medical society of which it is a part, and the page on which that listing begins.

Key to Abbreviations

Membership Status Codes

ACT*	Active Member
I&R	Active, Intern or Resident
DE4	Active Member, Dues Exempt — on temporary duty with the Armed Forces
A	Associate Member
AF	Affiliate Member
H	Honorary Member
R	Retired Member
S	Service Member
ST	Student Member

** The dues exempt classifications of DE-1, DE-5, and DE-7 (active members, according to the Bylaws), are now listed as "ACT," as are members on the sliding dues scale for junior and senior members. Billing class of active members may be determined by contacting the MAG headquarters office.*

Specialties of Practice

A	Allergy
ABS	Surgery, Abdominal
ADL	Adolescent Medicine
AL	Allergy & Immunology
AM	Aerospace Medicine
AN	Anesthesiology
BE	Broncho-Esophagology
BLB	Bloodbanking
CD	Cardiovascular Diseases
CDS	Surgery, Cardiovascular
CHN	Neurology, Child
CHP	Psychiatry, Child
CLP	Pathology, Clinical
CRS	Surgery, Colon & Rectal
D	Dermatology
DIA	Diabetes
DMP	Dermatopathology
DR	Radiology, Diagnostic
EM	Emergency Medicine
END	Endocrinology
FOP	Pathology, Forensic
FP	Family Practice
GE	Gastroenterology
GER	Geriatrics
GP	General Practice
GPM	General Preventive Medicine
GS	Surgery, General
GYN	Gynecology
HEM	Hematology
HNS	Surgery, Head & Neck
HS	Surgery, Hand
HYP	Hypnosis
ID	Infectious Diseases
IG	Immunology
IM	Internal Medicine
LAR	Laryngology
LM	Legal Medicine
MFS	Maxillofacial Surgery
N	Neurology
NA	Neuropathology
ND	Neoplastic Diseases
NEP	Nephrology
NM	Nuclear Medicine
NPM	Neonatal-Perinatal Medicine
NR	Nuclear Radiology
NS	Neurological Surgery
NTR	Nutrition
OBG	Obstetrics, Gynecology
OBS	Obstetrics
OM	Occupational Medicine
ON	Oncology
OPH	Ophthalmology
ORS	Orthopedic Surgery
OT	Otology
OTO	Otology, Laryngology, Rhinology, Otorhinolaryngology
P	Psychiatry
PA	Clinical Pharmacology
PD	Pediatrics
PDA	Pediatrics, Allergy
PDC	Pediatrics, Cardiology
PDE	Pediatric Endocrinology
PDR	Radiology, Pediatric
PDS	Surgery, Pediatric
PH	Public Health
PHO	Pediatric Hematology-Oncology
PM	Physical Medicine & Rehabilitation
PNP	Pediatric Nephrology
PS	Plastic Surgery
PTH	Pathology
PUD	Pulmonary Diseases
PYA	Psychoanalysis
PYM	Psychosomatic Medicine
R	Radiology
RHI	Rhinology
RHU	Rheumatology
RIP	Radioisotopic Pathology
TR	Radiology, Therapeutic
TRS	Surgery, Traumatic
TS	Surgery, Thoracic
U	Urology
US	Unspecified (Physician did not specify a specialty)
OS	Other Specialty (Physician designated a specialty other than those listed)

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ALPHABETICAL LIST

A

ABBOTT, EMILE G. 48 ACT IM
PO BOX 571, CONYERS 30207

ABDULLA, ABDULLA MOHAMMED 54 ACT IM
MEDICAL COLLEGE OF GEORGIA, AUGUSTA 30901

ABEL, RICHARD W. 29 ACT PD
5635 PEACHTREE PKY, NORCROSS 30071

ABELE, DONALD C. 54 ACT D
MEDICAL COLLEGE OF GEORGIA, AUGUSTA 30912

ABELLERA, E.Q. 16 ACT GS
28 DIX-LEE'ON DR, FAIRBURN 30213

ABEND, MELVIN N. 29 ACT GS
4553 NORTH SHALLOWFORD RD, ATLANTA 30338

ABERNATHY, A.H., III 29 ACT IM
105 COLLIER RD NW STE 1060, ATLANTA 30309

ABNEY, HOWARD T. 15 ACT GS
740 PRINCE AVE, ATHENS 30601

ABRAMSON, NORMAN 06 ACT R
770 PINE ST STE L-20, MACON 31201

ABRAMSON, PAUL J. 48 ACT R
ROCKDALE COUNTY HOSPITAL, CONYERS 30207

ABREU, VERGIL 08 ACT OBG
840 SYLVANIA RD, MILLEN 30442

ACHECAR, FRED A. 16 ACT NS
33 SW UPPER RIVERDALE RD, RIVERDALE 30274

ACKERMAN, LARRY L. 11 ACT P
530 E 49TH ST, SAVANNAH 31405

ACREE, JOHN W. 34 ACT FP
2 HOSPITAL ST, HIAWASSEE 30546

ACTON, WILLIAM C. 06 ACT DR
380 HOSPITAL DR, MACON 31201

ADAIR, HAROLD E. 29 ACT U
960 JOHNSON FERRY RD NE, ATLANTA 30342

ADAIR, M.C. 78 R FP
203 SIMS ST, WASHINGTON 30673

ADAMS, CHARLES P. 29 ACT GS
490 PEACHTREE ST NE #278-C, ATLANTA 30308

ADAMS, DANIEL M. 29 ACT OTO
2719 FELTON DR, EAST POINT 30344

ADAMS, ELIZABETH K. 29 S IM
730 PEACHTREE ST NE, ATLANTA 30365

ADAMS, JAMES M. 68 ACT IM
PO BOX 828, LA GRANGE 30240

ADAMS, JOHN B., JR. 26 ACT FP
408 EAST THIRD AVE, CORDELE 31015

ADAMS, MELVIN L. 06 ACT EM
3037 MALVERN HILL DR, MACON 31204

ADAMS, WILLIAM E. 47 ACT N
2119 WARM SPRINGS RD, COLUMBUS 31904

ADAMS, WILLIE, JR. 23 ACT OBG
320 SECOND AVE, ALBANY 31701

ADAMSON, JAMES W. 47 S IM
MARTIN ARMY HOSPITAL, FT BENNING 31905

ADAN, ANIBAL 22 ACT AN
755 COLUMBIA DR STE 413, DECATUR 30030

ADCOCK, DAVID W. 19 ACT ORS
1414 SOUTH MAIN ST, MOULTRIE 31768

ADDISON, BENJAMIN ALFRED 30 ACT GS
1001 NORTH THIRD ST, FOLKSTON 31537

ADERHOLT, HEWLETT EDWIN 29 ACT AN
1968 PEACHTREE RD NW, ATLANTA 30309

ADICKES, H.F., JR. 30 ACT P
412 OCEAN BLVD, ST SIMONS IS 31522

ADKINS, H.T. 72 R PH
807 CHEROKEE CIR, WAYCROSS 31501

ADLER, SAUL M. 29 ACT OS
5675 PEACHTREE DUNWOODY RD, ATLANTA 30342

AGOSTAS, W.N. 54 ACT IM
1021 15TH ST, AUGUSTA 30901

AGRAWAL, BIPIN 47 ACT IM,NEP
401 DOCTORS BLDG, COLUMBUS 31901

AGRAZ, RODOLFO R. 17 ACT AN
3830 SOUTH COBB DR STE 215-A, SMYRNA 30080

AGRIN, ALFRED 34 A P
NORTH GA MH-MR CENTER, GAINESVILLE 30501

AGUERO, OSCAR E. 56 ACT ORS
2704 NORTH OAK ST BLDG E, VALDOSTA 31602

AGUILAR, AGUSTIN 17 ACT AN
5662 QUEENSBOROUGH DR NE, ATLANTA 30338

AHMAD, AMBREEN A. 60 ACT P
PO BOX 372, TOCCOA 30577

AHMAD, NASEER 60 ACT PTH
759 HENDERSON FALLS RD, TOCCOA 30577

AHMANN, PETER A. 29 ACT CHN
1365 CLIFTON RD NE, ATLANTA 30322

AHN, JUNG HONG 68 ACT AN
747 AZALEA DR, LA GRANGE 30240

AHN, SOO WONG 22 ACT IM
8 LAVISTA PERIMETER OFC PK, TUCKER 30084

AHN, YOUNG W. 29 ACT OBG
25 PRESCOTT ST NE, ATLANTA 30308

AHRANO, JUDITH 60 ACT PD
800 EAST DOYLE ST, TOCCOA 30577

AICHER, JOHN A. 47 I&R
PO BOX 951, COLUMBUS 31994

AJOY, VICENTE R. 16 ACT GS
259-B ARROWHEAD BLVD, JONESBORO 30236

AKIN, JOHN T., JR. 29 ACT GS
35 COLLIER RD NW, ATLANTA 30309

AKSTEIN, RICARDO B. 16 ACT OPH
PO BOX 859, RIVERDALE 30274

AKTUNC, DOGAN R. 54 ACT IM
BOX 327, GRACEWOOD 30812

ALARCON, ALFREDO 29 ACT CDS
490 PEACHTREE ST NE, ATLANTA 30308

ALBEE, ROBERT B., JR. 29 ACT OBG
20 LINDEN AVE NE STE 7-C, ATLANTA 30365

ALBUQUERQUE, L. JOHN DE 17 ACT GS
1406 DREXEL CT, MARIETTA 30067

ALDAY, JAMES M., JR. 34 ACT ORS
650 BROAD ST SE, GAINESVILLE 30505

ALDEN, HERBERT S. 29 ACT D
3316 PIEDMONT RD NE STE 520, ATLANTA 30305

ALDERETE, JOSEPH F. 29 S P
1670 CLAIRMONT RD, DECATUR 30030

ALDERMAN, EARL L. 29 ACT GS
35 COLLIER RD NW, ATLANTA 30309

ALEXANDER, HAROLD H. 29 ACT ORS
6500 VERNON WOODS DR NE, ATLANTA 30328

ALEXANDER, J.L. 11 ACT TS,CDS
5400 SUTLIVE ST STE 1, SAVANNAH 31405

ALEXANDER, JAMES G. 11 ACT FP
508 EAST 61 ST, SAVANNAH 31405

ALEXANDER, JAMES H. 29 ACT PD
5675 PEACHTREE-DUNWOODY RD, ATLANTA 30342

ALEXANDER, MANUEL 37 ACT ORS
94 HOSPITAL RD, COMMERCE 30529

ALEXANDER, SUSAN 37 ACT OBG
94 HOSPITAL RD, COMMERCE 30529

ALEXANDER, W. SCOTT 13 ACT EM
FORSYTH CO HOSP ER, CUMMING 30130

ALFONSO, GABRIEL M. 02 A P
BOX 85, MILLEDGEVILLE 31062

ALFORD, TIM J. 47 I&R
PO BOX 951, COLUMBUS 31994

ALFRED, DEWITT C., JR. 29 ACT P
80 BUTLER ST SE, ATLANTA 30335

ALISAGO, ANDRES S., JR. 70 ACT AN
7694 EAST BRAINERD RD, CHATTANOOGA TN 37421

ALLAN, CHRISTOPHER J. 29 ACT PTH
1000 JOHNSON-FERRY RD, ATLANTA 30342

ALLARD, CHARLES 22 ACT FP
755 COLUMBIA DR STE 302, DECATUR 30030

ALLEN, ARTHUR T. 23 ACT AN
911 FIFTH AVE, ALBANY 31701

ALLEN, BRUCE S. 06 ACT D
800 FIRST ST STE 300, MACON 31201

ALLEN, CALVIN F., JR. 34 ACT AN
743 SPRING ST, GAINESVILLE 30505

ALLEN, EDWIN W., III 23 ACT EM
PO BOX 1828, ALBANY 31703

ALLEN, H.D., JR. 02 ACT P
PO BOX 827, MILLEDGEVILLE 31061

ALLEN, JOHN J. 15 ACT FP
160 TILLMAN LN, ATHENS 30606

ALLEN, LANE H. 54 ACT US
MEDICAL COLLEGE OF GEORGIA, AUGUSTA 30902

ALLEN, LEE T. 22 ACT U
755 COLUMBIA DR STE B, DECATUR 30030

ALLEN, MARSHALL B., JR. 54 ACT N
MEDICAL COLLEGE OF GEORGIA, AUGUSTA 30902

ALLEN, R.D. 10 R GP
45 HEAD AVE, TALLAPOOSA 30176

ALLEN, ROBERT C. 29 ACT OPH
1365 CLIFTON RD NE, ATLANTA 30322

ALLEN, STEPHEN C. 19 ACT U
#2 HOSPITAL PK, MOULTRIE 31768

ALLEN, THOMAS M. 53 ACT FP
PO BOX 482, DAWSON 31742

ALLEN-DALRYMPLE, BARBARA J. 37 ACT OBG
HOSPITAL RD, COMMERCE 30529

ALLGOOD, PIERCE 29 ACT ORS
35 COLLIER RD NW, ATLANTA 30309

ALLIGOOD, LAWRENCE 10 ACT PTH
TANNER MEMORIAL HOSPITAL, CARROLLTON 30117

ALLMAN, FRED L. 29 ACT ORS
615 PEACHTREE ST NE STE 1100, ATLANTA 30308

ALLSBROOK, WILLIAM C. 54 ACT PTH
MEDICAL COLLEGE OF GEORGIA, AUGUSTA 30912

ALMAND, JOSEPH M., JR. 68 ACT PD
606 SOUTH GREENWOOD ST, LA GRANGE 30240

ALMEROTH, ROBERT H., JR. 22 ACT FP
1462 MONTREAL RD STE 307, TUCKER 30084

ALMONTE, ILDEFONSO G.D. 47 A DR
1901 LANCASTER DR, COLUMBUS 31904

ALONSO, KENNETH B. 38 ACT PTH
2921 MARGARET MITCHELL CT NW, ATLANTA 30327

ALPERIN, HENRY 54 ACT R
1450 WINTER ST, AUGUSTA 30904

ALPERIN, HERBERT 29 ACT PD
5675 PEACHTREE-DUNWOODY RD, ATLANTA 30342

ALPERN, ROBERT J. 17 ACT CHP
3995 SOUTH COBB DR, SMYRNA 30081

ALPERT, HAROLD M. 29 ACT PUD
3250 HOWELL MILL RD STE 105, ATLANTA 30327

ALTHISAR, H.M., SR. 54 ACT FP
4 EAGLETON CT, AUGUSTA 30909

ALVARADO, ROMULO R. 56 ACT PD
405 COWART AVE, VALDOSTA 31602

ALVAREZ, ANGEL C. 47 ACT PD
713 20TH ST, COLUMBUS 31904

ALVAREZ, H.W. 02 ACT P
CENTRAL STATE HOSPITAL, MILLEDGEVILLE 31061

ALVAREZ, M.L. 11 ACT PTH
12903 LARGO DR, SAVANNAH 31406

ALVAREZ, RAFAEL A. 02 ACT P
HOWELL 4 SOUTH, MILLEDGEVILLE 31062

ALVAREZ, RAMON V. 24 ACT FP
PO DRAWER 170, ST MARYS 31558

ALVAREZ-MENA, SERGIO C. 02 ACT IM
PO BOX 637, HARDWICK 31034

ALVIG, OLAV H. 13 ACT DR
BOX 768, CUMMING 30130

AMATRIAIN, F.F. 22 ACT OBG
5040 SNAPFINGER WOODS DR, DECATUR 30035

AMBROSE, SAMUEL S., JR. 29 ACT U
1365 CLIFTON RD NE, ATLANTA 30322

AMERSON, J. RICHARD 29 ACT GS
EMORY UNIVERSITY CLINIC, ATLANTA 30322

AMIE, JACK M. 30 ACT U
2418 PARKWOOD DR, BRUNSWICK 31520

AMIR-ATEFI, DAVID 29 ACT
3993 LAWRENCEVILLE HWY, LILBURN 30247

AMMONS, JOHN C. 29 S N
1670 CLAIRMONT RD NE, DECATUR 30033

AMOS, WILLIAM L., JR. 47 ACT OBG
2022 10TH AVE, COLUMBUS 31901

AMSTER, STEVEN M. 75 ACT AN
WAYNE MEMORIAL HOSP BOX 408, JESUP 31545
ANAGNOSTAKIS, JOHN G. 32 ACT FP
9507 HWY 5, DOUGLASVILLE 30135
ANASTASIADES, K. DINOS 29 I&R
3922 WEST WOOD PATH, STONE MOUNTAIN 30083
ANDERS, MACELYN V. 08 R FP
203 WILDWOOD DR, STATESBORO 30458
ANDERS, PATRICK L. 29 ACT OBG
2726-A FELTON DR, EAST POINT 30344
ANDERS, REBEKAH Y. 29 ACT FP
2726-A FELTON DR, EAST POINT 30344
ANDERSON, BENJAMIN S., JR. 27 ACT FP
PO BOX 508, CEDARTOWN 30125
ANDERSON, GROVER L. 29 ACT NS
315 BOULEVARD NE STE 300, ATLANTA 30312
ANDERSON, H. VERNON 29 I&R
2502 KINGSCLIFF DR, ATLANTA 30345
ANDERSON, JAMES D., JR.(DDS) 29 AF
6075 ROSWELL RD NE, ATLANTA 30328
ANDERSON, JOHN D. 56 ACT IM
2311 NORTH PATTERSON ST, VALDOSTA 31602
ANDERSON, JOHN L., JR. 06 ACT R
4715 GUERRY DR, MACON 31210
ANDERSON, ROBERT H., JR. 34 ACT GS
194 GOLD ST, GAINESVILLE 30501
ANDERSON, ROBERT T. 14 ACT DR
5 ETOWAH TER, CANTON 30114
ANDERSON, THOMAS J., JR. 29 ACT IM
490 PEACHTREE ST NE, ATLANTA 30308
ANDERSON, THOMAS L. 56 ACT PD,NPM
STE 209 PENDLETON RD, VALDOSTA 31602
ANDERSON, W.R. 61 ACT PD
PO BOX 568, AMERICUS 31709
ANDERSON, WALTER F. 29 S P
2531 BRIARCLIFF RD NE, ATLANTA 30329
ANDERSON, WILLIAM B. 29 ACT P
1462 MONTREAL RD, TUCKER 30084
ANDERSON, WILLIAM J. 22 ACT FP
755 COLUMBIA DR STE 333, DECATUR 30030
ANDREWS, CATHERINE S. 17 ACT FP
2931 SOUTH MAIN ST, KENNESAW 30144
ANDREWS, CHARLES R., JR. 14 ACT GS
PO BOX 308, CANTON 30114
ANDREWS, H. GIBBS 22 ACT PDS
1901 CENTURY BLVD NE STE 11, ATLANTA 30345
ANDREWS, JAMES R. 47 ACT ORS
6262 HAMILTON RD, COLUMBUS 31904
ANDREWS, JOHN RONALD 23 ACT R
PO BOX 1924, ALBANY 31703
ANDREWS, RUSSELL E. 27 ACT OBG
316 WEST TENTH ST STE A, ROME 30161
ANGELL, JOHN H. 11 ACT OBG
PO BOX 22729, SAVANNAH 31403
ANSARI, AMIR H. 29 ACT OBG
300 BOULEVARD NE, ATLANTA 30312
ANTHONY, H.F., JR. 69 ACT R
MEDICAL COLLEGE OF GEORGIA, AUGUSTA 30901
ANTON, BLANCA R. 29 ACT CHP
1970 CLIFF VALLEY WAY NE, ATLANTA 30329
ANTON, MANUEL P. 29 A P
99 BUTLER ST SE, ATLANTA 30303
APANAY, MANOLO B. 16 ACT GS
250 ARROWHEAD BLVD, JONESBORO 30236
APGAR, J. THOMAS 22 ACT D
1462 MONTREAL RD STE 203, TUCKER 30084
APPEL, SIDNEY D. 22 ACT GS
1462 MONTREAL RD STE 205, TUCKER 30084
APPELRDUTH, DANIEL J. 29 ACT RHU
993-D JOHNSON FERRY RD NE, ATLANTA 30342
ARANAS, CATALINA T. 47 ACT OBG
217 DOCTORS BLDG, COLUMBUS 31901
ARANAS, TEOFREDO C. 47 A DR
6925 SPRING LAKE DR, COLUMBUS 31904
ARANDA, RICARDO J. 27 ACT OBG
320 WEST NINTH ST, ROME 30161

ARANGD, VIRGILIO A. 29 ACT PD
35 LINDEN AVE NE, ATLANTA 30308
ARENSMAN, FREDERICK W. 54 ACT PD,CD
MEDICAL COLLEGE OF GEORGIA, AUGUSTA 30912
ARKIN, MURRAY C. 11 ACT IM
PO BOX 15238, SAVANNAH 31416
ARMSTRONG, EDWARD S. 23 ACT IM
1603 WEST THIRD AVE, ALBANY 31707
ARMSTRONG, NATHANIEL E. 30 ACT GS
PO BOX 1258, BRUNSWICK 31520
ARNALL, JOHN ROBERT 36 ACT FP
PO DRAWER G, PERRY 31069
ARNETT, THOMAS E. 65 ACT OBG
706 SOUTH BROAD ST, THOMASVILLE 31792
ARNOLD, J.H. 20 ACT FP
PO BOX 279, NEWNAN 30263
ARNOLD, JOSEPH A. 22 ACT GP
2910 NORTH DRUID HILLS RD NE, ATLANTA 30329
ARNOLD, MCALPIN H. 12 ACT FP
46 LAUREL DR, ELBERTON 30635
ARONOVITZ, GERSON H. 22 ACT PD
2714 CLAIRMONT RD NE, ATLANTA 30329
ARORA, OM P. 33 ACT GS
221 NORTH MAIN ST, CORNELIA 30531
ARORA, VIJAY 33 ACT PD
221 NORTH MAIN ST, CORNELIA 30531
ARRUE, LUIS R. 48 ACT PD
4114 MILL ST NE, COVINGTON 30209
ARSEVEN, H. OGUZ 29 ACT AN
PO BOX 743, LITHIA SPRINGS 30057
ARSHAD, MOHAMMAD 29 ACT OBG
804 MAIN ST 'B, FOREST PARK 30050
ARTIME, MANUEL E. 22 ACT A
2191 NORTHLAKE PKY, TUCKER 30084
ARUNACHALAM, KRISHNAN 18 ACT IM
PO BOX 1409, DOUGLAS 31533
ARWOOD, WILLIAM C., JR. 46 ACT FP
HAND AVE, PELHAM 31779
ASBELL, JIMMY R. 06 ACT ORS
380 HOSPITAL DR, MACON 31201
ASERON, CIRILO, JR. 08 ACT R
307 NORTHSIDE DR E, STATESBORO 30458
ASHER, HAROLD 29 ACT GE
5669 PEACHTREE-DUNWOODY RD, ATLANTA 30342
ASHLEY, JULIA V. 03 ACT GS
223 SOUTH MADISON, MONROE 30655
ASKEW, DANNY E. 34 ACT OBG
1211 SHERWOOD PARK DR, GAINESVILLE 30501
ASKEW, JAMES L. 16 ACT R
PO BOX 699, RIVERDALE 30274
ASKREN, EDWARD L., JR. 29 ACT OPH
1293 PEACHTREE ST NE, ATLANTA 30309
ASSAD, RAMZI T. 54 ACT IM
MEDICAL COLLEGE OF GEORGIA, AUGUSTA 30912
ASTIN, PHIL C., JR. 10 ACT FP
702 DIXIE ST, CARROLLTON 30117
ATHA, JDHN F. 27 ACT FP
HOGUE AVE, ROCKMART 30153
ATHA, WILLIAM J., JR. 27 ACT
20 RIVERMONT DR SW, ROME 30161
ATKINS, EARNEST C. 22 ACT GS
2910 NORTH DRUID HILLS RD, ATLANTA 30329
ATKINS, KENNEY S. 07 ACT GP
7 MAIN ST, MCCAYSVILLE 30555
ATKINS, SAM O. 29 ACT U
2600 ML KING JR BLVD SW, ATLANTA 30311
ATKINSON, GEORGE O. 29 ACT PDR
1405 CLIFTON RD NE, ATLANTA 30322
ATKINSDN, H.C. 06 ACT IM
111 BUFORD PL, MACON 31204
ATKINSON, JOHN P. 06 ACT IM
724 HEMLOCK ST, MACON 31201
ATKINSON, STEWART 29 ACT OPH
615 PEACHTREE ST NE, ATLANTA 30308
ATKINSON, THEDDDRE E. 06 ACT R
770 PINE ST STE 250, MACON 31210

ATLURI, RAVATI 22 ACT IM
2754 NORTH DECATUR RD, DECATUR 30030
ATWATER, JOHN S. 29 ACT IM,GE
478 PEACHTREE ST NE, ATLANTA 30308
ATWATER, PAUL C. 29 ACT OTO
105 COLLIER RD NW STE 4040, ATLANTA 30309
AUDA, STEPHEN P. 29 ACT GS,ON
100 NORTH PARK CENTER, FAYETTEVILLE 30214
AUGUST, GARRY LEWIS 47 ACT IM
500 18TH ST STE B-50, COLUMBUS 31901
AUPONT, PIERRE P.A. 16 ACT AN
597 CONWAY FOREST DR, ATLANTA 30327
AUSTIN, COLLEEN S. 29 ACT IM
5669 PEACHTREE DUNWOODY RD, ATLANTA 30342
AUSTIN, G.J., JR. 56 ACT PD
DOCTORS BLDG STE 202, VALDOSTA 31602
AUSTIN, HOWARD M. 16 ACT R
PO BOX 1255, RIVERDALE 30274
AUSTIN, J.L. 59 ACT OTO

AUSTIN, WILLILAM F. 30 ACT FP
3011 KEMBLE, BRUNSWICK 31520
AVANT, EARL S. 06 ACT AN
2770 NORTH WOODS DR, MACON 31204
AVERA, BERTRAM PRICE, JR. 42 R IM
302 STONE ST, WRENS 30833
AVERA, JOHN B. 30 ACT GS

AVERETT, JACK M., JR. 47 ACT IM
2300 MANCHESTER EXPY, COLUMBUS 31904
AVERETT, JAMES E., JR. 29 ACT ORS
105 COLLIER RD NW STE 2010, ATLANTA 30309
AVERITT, THOMAS E. 44 R FP
PO BOX 897, THOMSON 30824
AVERY, WILLIAM G. 29 ACT GYN
275 CARPENTER DR NE, ATLANTA 30328
AVRET, EDWIN T. 22 ACT IM
4151 MEMORIAL DR 105-B, DECATUR 30032
AYER, G. DARRELL, JR. 29 ACT PTH
BOX 12466, ATLANTA 30355
AYERS, GARY R. 29 ACT TR
1000 JOHNSON FERRY RD NE, ATLANTA 30342
AYERS, WILLIAM T., JR. 68 ACT GS
303 SMITH ST, LA GRANGE 30240
AYOUB, MACRAM M. 06 ACT GS
MEDICAL CENTER OF CENTRAL GA, MACON 31208
AYRES, J. ALEXANDER 22 ACT OPH
542 CHURCH ST STE 232, DECATUR 30030
AZAHAR, RAMDN P. 02 ACT U
168 FORT WILKINSON RD, MILLEDGEVILLE 31061
AZAR, GORDON J. 29 ACT IM
960 JOHNSON FERRY RD NE, ATLANTA 30342
AZIZ, EZZAT M., MD DIR 54 ACT PD
1350 WALTON WAY (10), AUGUSTA 30910

B

BABALIAROS, CDNSTANTINE N. 29 ACT GS
1203 CLEVELAND AVE ' 1-B, EAST POINT 30344
BACKERMAN, IVAN A. 29 ACT OBG
1311 CLEVELAND AVE, EAST POINT 30344
BAGHERI, M.T. 13 ACT TS
719 SCENIC HWY SW, LAWRENCEVILLE 30245
BAGLEY, CHARLES E. 72 ACT FP
PO BOX 220, ALMA 31510
BAILEY, A. GLENN 68 ACT GS
303 SMITH ST, LA GRANGE 30240
BAILEY, ANN A. 45 ACT OS
GA WARM SPRINGS HOSP, WARM SPRINGS 31830
BAILEY, HENRY WRIGHT 54 ACT GS
1443 ANTHONY RD, AUGUSTA 30904
BAILEY, JAMES A. 29 ACT PM
1368 OAKCREST DR SW, ATLANTA 30311
BAILEY, JOSEPH P. 54 ACT IM
TALMADGE HOSPITAL, AUGUSTA 30912

BAILEY, PHILIP B. 76 ACT CD
1217 MEMORIAL DR, DALTON 30720
BAILEY, T.E. 54 ACT PD
1111 DRUID PARK AVE, AUGUSTA 30904
BAILEY, THOMAS E., JR. 54 ACT ORS
820 ST SEBASTIAN WAY, AUGUSTA 30910
BAILEY, WILLIAM M. 06 ACT CD
618 ORANGE ST, MACON 31201
BAIRD, JOSEPH B., JR. 29 ACT P
1938 PEACHTREE RD NW, ATLANTA 30309
BAIRD, L. STEPHENS 29 ACT GS
1835 DELOWE DR SW, ATLANTA 30311
BAISDEN, C.ROBERT 54 ACT PTH
MEDICAL COLLEGE OF GEORGIA, AUGUSTA 30901
BAKAY, ROY A.E. 22 ACT GS,NS
1365 CLIFTON RD NE, ATLANTA 30322
BAKER, BONNER L. 06 ACT IM
811 ORANGE TERR, MACON 31201
BAKER, CHAMP L., JR. 47 ACT ORS
6262 HAMILTON RD, COLUMBUS 31904
BAKER, J. JAY 29 ACT ON
993-D JOHNSON FERRY RD NE, ATLANTA 30342
BAKER, JOHN B. 23 ACT N
500 THIRD AVE #102, ALBANY 31701
BAKER, L. DWIGHT, JR. 68 ACT GS
301 MEDICAL DR STE 506, LA GRANGE 30240
BAKER, LAWRENCE D. 29 ACT GP
2150 PEACHFORD RD STE B, ATLANTA 30338
BAKER, ROY P. 11 ACT NS
4 JACKSON BLVD, SAVANNAH 31405
BAKER, W.R. 50 ACT GS
COMMERCE ST, HAWKINSVILLE 31036
BALA, AYER 11 ACT IM,ON
PO BOX 22429, SAVANNAH 31403
BALBONA, JOSE L. 29 ACT P
1935 CLIFF VALLEY WAY NE, ATLANTA 30329
BALCH, THOMAS S. 29 ACT IM
3280 HOWELL MILL RD NW, ATLANTA 30327
BALDWIN, B. CARTER 47 ACT D
3408 CODY RD, COLUMBUS 31907
BALL, HENRY FAVER 54 ACT P
2350 WASHINGTON RD, AUGUSTA 30904
BALL, HORACE C. 22 ACT OBG
755 COLUMBIA DR STE 503, DECATUR 30030
BALL, LARRY T. 22 ACT IM
2054-B LAWRENCEVILLE HWY, DECATUR 30033
BALL, TURNER I. 29 ACT PDR
1405 CLIFTON RD NE, ATLANTA 30322
BALL, WESLEY J. 11 ACT GS
1814 ABERCORN ST, SAVANNAH 31401
BALLARD, DAVID C., III 17 ACT IM
652 CHURCH ST STE C, MARIETTA 30060
BALLARD, JULIA E. 29 ACT IM
1968 PEACHTREE RD, ATLANTA 30309
BALLARD, MARGUERITE C. 29 S IM
3092 ARGONNE DR NW, ATLANTA 30305
BAMFORD, SOPHIA 78 ACT PTH
119 GORDON ST, WASHINGTON 30673
BANCKER, EVERT A. 29 ACT IM
125 RIVER NORTH DR NW, ATLANTA 30328
BANDERAS, JULIO C. 16 ACT ORS
113 UPPER RIVERDALE RD, RIVERDALE 30274
BANKER, DIPAK S. 02 ACT PD,HEM
511 N COBB ST STE 11, MILLEDGEVILLE 31061
BANNISTER, PHILLIP N. 60 ACT OBG
800 EAST DOYLE ST, TOCCOA 30577
BANTLY, THOMAS W. 22 ACT P
2754 NORTH DECATUR RD, DECATUR 30030
BARDACK, RICHARD A. 17 ACT CD
833 CAMPBELL HILL ST ' 460, MARIETTA 30090
BARFIELD, JAMES E. 57 ACT GP
PO BOX 1187, VIDALIA 30474
BARFIELD, WILLIAM E., JR. 54 ACT OBG
820 ST SEBASTIAN WAY STE 6C, AUGUSTA 30902
BARFIELD, WILLIAM E., SR. 54 ACT OBG
1510 JOHNS RD, AUGUSTA 30904
BARGERON, EUGENE P. 11 ACT ORS
PO BOX 22787, SAVANNAH 31405
BARIA, WILLIAM H. 22 ACT IM
105 COLLIER RD NW STE 2050, ATLANTA 30309
BARKER, CHARLES O. 56 ACT FP
2704 NORTH OAK ST BLDG A-2, VALDOSTA 31602
BARKSDALE, C.R., JR. 29 R FP
RICO LAKE RD, PALMETTO 30268
BARNARD, BENJAMIN C. 57 ACT FP
PO BOX 1127, VIDALIA 30474
BARNES, JOHN J. 29 ACT OBG
2045 PEACHTREE RD NE, ATLANTA 30309
BARNES, JOSEPH H. 29 ACT OBG
993 JOHNSON FERRY RD NE, ATLANTA 30342
BARNES, STEPHEN N. 59 ACT ORS
610 SOUTH EIGHTH ST, GRIFFIN 30223
BARNES, WADDELL 06 ACT IM
800 SPRING ST, MACON 31201
BARNES, WALTER P., JR. 06 ACT ORS
671 HEMLOCK ST, MACON 31201
BARNETT, CRAWFORD F., JR. 29 ACT IM
3250 HOWELL MILL RD NW, ATLANTA 30327
BARNETT, J.C., JR. 17 ACT NS
776 CANTON RD, MARIETTA 30060
BARNETT, JOHN E., JR. 29 ACT P
6363 ROSWELL RD NE, ATLANTA 30328
BARNETT, STEPHEN M. 29 ACT GS
105 COLLIER RD NW, ATLANTA 30309
BARNETT, STEPHEN T., JR. 29 ACT OBG
PO BOX 1424, HIGHLANDS NC 28741
BARNWELL, WILLIAM L. 76 ACT OPH
1111 PROFESSIONAL BLVD, DALTON 30720
BARR, ROBERT E. 26 ACT FP
408 EAST THIRD AVE, CORDELE 31015
BARRON, WILLIAM E., JR. 20 ACT IM
PO BOX 609, NEWNAN 30263
BARROW, J. GORDON 32 ACT IM
110-B DOUGLAS MED COMPLX, DOUGLASVILLE 30134
BARRY, WILLIAM E. 15 ACT D
740 PRINCE AVE, ATHENS 30601
BARTHOLOMEW, PHILIP R. 29 ACT OBG
960 JOHNSON FERRY RD NE, ATLANTA 30342
BARTON, DEWEY L. 56 ACT R
2704-D NORTH OAK ST, VALDOSTA 31602
BARTON, IRENE D. 29 ACT P
34 BAL BAY DR #8, BAL HARBOUR FL 33154
BARTON, WILLIAM L. 06 ACT OTO
744 FIRST ST, MACON 31201
BASHINSKI, BENJAMIN, III 54 ACT N
3623 J DEWEY GRAY CIR #107, AUGUSTA 30909
BASHINSKI, BENJAMIN, JR. 06 R U
445 LAMAR DR, MACON 31210
BASKIN, J. HAGAN 29 ACT CDS
35 COLLIER RD NW STE 385, ATLANTA 30309
BASS, F. DONALD 20 ACT GS
PO BOX 609, NEWNAN 30263
BASSETT, WILBUR B., JR. 47 ACT IM
615 - 19TH ST, COLUMBUS 31901
BATCHELOR, CURTIS A. 10 ACT FP
405 ALABAMA ST, BREMEN 30110
BATEMAN, J. DAN 23 ACT GS
PO BOX 1170, ALBANY 31702
BATEMAN, NEEDHAM B. 29 ACT GS
573 WEST PEACHTREE ST NW, ATLANTA 30308
BATES, DEBORAH J. 54 ACT IM,EM
3940 WASHINGTON RD, MARTINEZ 30907
BATES, JACK M. 34 ACT P
664 LANIER PARK DR, GAINESVILLE 30505
BATES, JACKSON H. 17 ACT IM
52 TOWER RD NW, MARIETTA 30060
BATES, JOHN G. 53 ACT FP
201 RANDOLPH ST, CUTHBERT 31740
BATES, ROGER A. 72 ACT GS
2005 PIONEER ST, WAYCROSS 31501
BATES, W.B., JR. 72 ACT FP
1415 ALICE ST, WAYCROSS 31501
BATH, NICHOLAS M. 22 ACT U
755 COLUMBIA DR STE B, DECATUR 30030
BATRA, PRAMOD K. 01 ACT GS
204 EAST TOLLISON ST, BAXLEY 31513
BATTEY, L.L. 54 ACT CD
820 ST SEBASTIAN WAY STE 6A, AUGUSTA 30902
BATTEY, PATRICK M. 29 I&R
GRADY MEMORIAL HOSPITAL, ATLANTA 30303
BATTLE, LEE H., JR. 27 ACT GS
321 WEST SEVENTH ST, ROME 30163
BATTS, A.S. 50 ACT GP
116 LUMPKIN ST, HAWKINSVILLE 31036
BAUGH, WILBUR E. 02 ACT R
PO BOX 926, MILLEDGEVILLE 31062
BAUMGARTNER, BRUCE R. 29 ACT R
1365 CLIFTON RD NE, ATLANTA 30322
BAUTE, ANTONIO V. 29 ACT IM,CD
1100 CLEVELAND AVE ' 200, EAST POINT 30344
BAUTISTA, GRACE C. 62 ACT PD
214 FRASER DR, HINESVILLE 31313
BAUTISTA, VICTOR C. 62 ACT AN
PO BOX 87, MIDWAY 31320
BAXLEY, JOHN B., III 54 ACT FP
1417 PENDLETON RD, AUGUSTA 30904
BAXLEY, WILLIAM W., JR. 06 ACT OTO
380 HOSPITAL DR, MACON 31201
BAYDAR, ISIK D. 27 ACT IM
508 NORTH MAIN ST, CEDARTOWN 30125
BAYNE, LOUI G. 29 ACT ORS
960 JOHNSON FERRY RD NE, ATLANTA 30342
BAZEMORE, J. MALCOLM 54 ACT D
3023 PINE NEEDLE RD, AUGUSTA 30909
BEACH, BESSIE MAE 47 ACT PD
17 BALENTINE DR, GREENVILLE SC 29605
BEACH, WILLIAM R., III 32 ACT PTH
8954 HOSPITAL DR, 105-B, DOUGLASVILLE 30134
BEALL, AVERY P. 56 ACT IM
2301-C UNIVERSITY DR, VALDOSTA 31602
BEALL, JAMES H. 15 ACT P
700 OGLETHORPE AVE, ATHENS 30606
BEAN, JAMES L. 29 ACT OBG
PO BOX 5047, ROSWELL 30077
BEARD, CARL L. 36 R OBG
123 TANGLEWOOD DR, WARNER ROBINS 31093
BEARD, CHARLENE H. 22 ACT PD
5565 MEMORIAL DR 'D, STONE MOUNTAIN 30083
BEASLEY, ERNEST W., JR. 29 ACT IM,END
478 PEACHTREE ST NE, ATLANTA 30308
BEATTIE, JAMES F., JR. 70 ACT PTH
100 GROSS CRESCENT, FORT OGLETHORPE 30742
BECHTEL, H. BERNARD 56 ACT D
2101 NORTH PATTERSON ST, VALDOSTA 31601
BECKER, BRUCE H. 29 ACT OPH
3280 HOWELL MILL RD STE 243, ATLANTA 30327
BECKWITH, MERTON M. 54 ACT PS
PO BOX 3726, AUGUSTA 30904
BECTON, JAMES L. 54 ACT ORS
1521 ANTHONY RD (10), AUGUSTA 30910
BEDELL, DAVID T. 29 ACT P
777 CLEVELAND AVE SW, ATLANTA 30315
BEDINGFIELD, CARL O. 42 ACT PD
306 WEST GAINES ST, DUBLIN 31021
BEDINGFIELD, HERBERT M. 11 ACT ORS
600-I EAST 67TH ST, SAVANNAH 31405
BEDINGFIELD, JAMES A. 01 ACT FP
TIPPENS ST, BAXLEY 31513
BEDINGFIELD, W.H. 57 ACT FP
PO BOX 629, VIDALIA 30474
BEDINGFIELD, W.R., JR. 54 ACT IM
503 GEORGIA AVE, N AUGUSTA SC 29841
BEECHAM, PAUL E. 17 ACT P
833 CAMPBELL HILL ST #440, MARIETTA 30090
BEESON, CHARLES W., II 11 ACT CD
8 WHEELER ST, SAVANNAH 31405

BEESON, J. DANIEL 65 ACT AN
908 EAST WASHINGTON ST, THOMASVILLE 31792
BEHRMANN, PAUL J. 43 ACT FP
HWY 53 WEST, DAWSONVILLE 30534
BELCHER, WILLIAM T., JR. 22 ACT OPH
2754 NORTH DECATUR RD #115, DECATUR 30030
BELEN, RUBEN B. 47 ACT EM
6101 GARRET RD, MIDLAND 31820
BELK, BEVERLY 54 I&R PD
3370 TANGLEWOOD DR, AUGUSTA 30909
BELL, CHARLES B. 22 ACT IM
465 WINN WAY STE 150, DECATUR 30030
BELL, EUGENE D. 18 R FP
PO BOX 1267, DOUGLAS 31533
BELL, EUGENE D., JR. 06 ACT U
770 PINE ST STE 520, MACON 31201
BELL, FRANK C. 29 ACT OPH
5675 PEACHTREE DUNWOODY RD, ATLANTA 30342
BELL, HUGH V., JR. 29 ACT PTH
2736 FELTON DR, EAST POINT 30344
BELL, J.A., JR. 42 ACT FP
DUBLIN MEDICAL ARTS CENTER, DUBLIN 31021
BELL, J.E. 54 ACT PD
2211 CRESTWOOD DR, AUGUSTA 30904
BELL, RUDOLPH 65 ACT U
PO BOX 1675, THOMASVILLE 31792
BELL, SIDNEY A. 27 ACT ORS
HARBIN CLINIC, ROME 30161
BELLAM, RAMAMOHANA R. 30 ACT AN
3215 SHRINE RD, BRUNSWICK 31520
BELLVILLE, CHARLES G. 21 R GS
1602 DOUGLAS DR, BAINBRIDGE 31717
BELTRAN, SIMON E. 16 ACT
PO BOX 314, RIVERDALE 30274
BENDINS, KARLIS 16 ACT GP
607 FAYETTEVILLE RD, JONESBORO 30236
BENIGNO, BENEDICT B. 29 ACT GYN
993-F JOHNSON FERRY RD, ATLANTA 30342
BENNETT, GARLAND P., JR. 22 ACT FP
755 COLUMBIA DR STE 333, DECATUR 30030
BENNETT, HENRY A 24 AF US
709 WEST CONYERS ST, ST MARYS 31558
BENNETT, J.W. 54 ACT PD
820 ST SEBASTIAN STE 1-B, AUGUSTA 30902
BENNETT, RICHARD G. 29 ACT OS
5667 PEACHTREE DUNWOODY RD, ATLANTA 30342
BENNETT, VAN B. 56 R IM
RTE 1 BOX 1 COUNTRY CLUB RD, VALDOSTA 31601
BENNETT, WILLIAM H. 29 ACT U
6 HOWELL MILL PLANTATION, ATLANTA 30327
BENNETT, WILLIAM J. 22 ACT IM
1462 MONTREAL RD STE 214, TUCKER 30084
BENSON, EARL B. 17 ACT AN
1500 BEAUMONT DR, KENNESAW 30144
BENSON, H. BAGLEY 29 ACT PD
5675 PEACHTREE-DUNWOODY RD, ATLANTA 30342
BENSON, JOY F. 76 ACT PH
BRYANT CROSSING, DALTON 30720
BENSON, KENNETH C. 29 ACT OPH
5635 PEACHTREE PKY STE 180, NORCROSS 30092
BENSON, RICHARD L. 18 ACT R
BOX 1077, DOUGLAS 31533
BENSON, W.H., JR. 17 ACT IM
3188 ATLANTA ST SE, SMYRNA 30080
BERENS, SANFORD V. 11 ACT R
5223 PAULSEN ST, SAVANNAH 31405
BERENSON, JOEL E. 29 ACT DR
300 BOULEVARD NE, ATLANTA 30312
BERENSON, MORTON P. 47 ACT IM
1905 SEVENTH AVE, COLUMBUS 31901
BERG, EDWARD W. 54 ACT ORS
MEDICAL COLLEGE OF GEORGIA, AUGUSTA 30912
BERG, JOSEPH L. 23 ACT OPH
PO BOX 483, ALBANY 31702
BERGER, ISRAEL REUBEN 15 R R
I 703 W CHARLESTON BLVD, LAS VEGAS NV 89102
BERGER, LOUIS 29 ACT OPH
1218 BRIAR HILLS DR NE, ATLANTA 30306
BERGERON, GLYNN A. 11 ACT DR
5223 PAULSEN ST, SAVANNAH 31405
BERGGREN, RALPH E. 06 ACT FP
MERCER UNIVERSITY MED SCHOOL, MACON 31207
BERGHERM, BRUCE A. 29 ACT AN
5745 WINTERTHUR LN NW, ATLANTA 30328
BERGMAN, BERNARD A. 29 ACT CHP,P
3280 HOWELL MILL RD STE 230, ATLANTA 30327
BERKOWITZ, ROBERT B. 17 ACT A
833 CAMPBELL HILL ST #490, MARIETTA 30090
BERMAN, DAVE 47 ACT D
1918 COUNTRY CLUB RD, COLUMBUS 31906
BERMAN, IRWIN R. 30 ACT CRS
2301 PARKWOOD DR, BRUNSWICK 31520
BERMAN, JEROME D. 29 R PD
9715 HUNTCLIFF TR, DUNWOODY 30338
BERMAN, MERRILL 17 ACT R
1676 MULKEY RD SW, AUSTELL 30001
BERN, GERHARD O. 29 R IM
275 FIFTH ST NW, ATLANTA 30318
BERNSTEIN, JEFFREY A. 29 ACT OBG
2550 WINDY HILL RD STE 206, MARIETTA 30067
BERNSTEIN, RICHARD B. 29 ACT N
3280 HOWELL MILL RD NW, ATLANTA 30327
BERRY, ARNOLD J. 29 ACT AN
1364 CLIFTON RD NE, ATLANTA 30322
BERRY, C. MARKHAM 29 ACT P
6111 PEACHTREE DUNWOODY RD, ATLANTA 30328
BERRY, J. NORMAN 29 ACT IM
6500 VERNON WOODS DR NE, ATLANTA 30328
BERRY, MAXWELL R., JR. 29 R GE
BOX 1099, BIG CANOE 30143
BERRY, NEIL C. 16 ACT ORS
33 SW UPPER RIVERDALE RD, RIVERDALE 30274
BERRY, ROBERT L. 10 R FP
611 NORTH AVE, VILLA RICA 30180
BERSON, MICHAEL J. 48 ACT U
4140 TATE ST, COVINGTON 30209
BESTAWROS, ONSY A. 76 ACT R
PO BOX 1285, DALTON 30720
BETHEA, JAMES S., III 29 ACT ORS
5669 PEACHTREE-DUNWOODY RD, ATLANTA 30342
BEVERIDGE, WAYNE D. 54 ACT N
MEDICAL COLLEGE OF GEORGIA, AUGUSTA 30912
BICKERS, DONALD 29 ACT NS
3250 HOWELL MILL RD NW, ATLANTA 30327
BICKERSTAFF, HUGH J. 47 ACT OBG
2228 WILDWOOD, COLUMBUS 31906
BICKERSTAFF, JAMES W., JR. 72 ACT ORS
1921 ALICE ST, WAYCROSS 31501
BIELING, FRIEDRICH C. 22 ACT OBG
5040 SNAPFINGER WOODS DR, DECATUR 30035
BIENERT, HENRY J. 29 ACT ORS
1311 CLEVELAND AVE, EAST POINT 30344
BIGGER, JOHN F., JR. 54 ACT OPH
905 15TH ST STE E, AUGUSTA 30901
BIGGERS, WILLIAM H. 29 ACT P
3280 HOWELL MILL RD STE 230, ATLANTA 30327
BIGGERSTAFF, EDWARD D., III 11 ACT OBG
PO BOX 22788, SAVANNAH 31405
BIKOFF, WILLIAM S. 29 ACT N
315 BOULEVARD NE STE 224, ATLANTA 30312
BILSTEN, GEORGE G.B. 29 ACT N
35 COLLIER RD NW, ATLANTA 30309
BIRDSONG, WILLIAM R. 06 ACT FP
531 NORTH AVE, MACON 31201
BISHKO, JAY R. 34 ACT AN
PO BOX 2979, GAINESVILLE 30503
BISHOP, EMMETT R., JR. 11 ACT P
210 EAST HALL ST, SAVANNAH 31401
BISHOP, JOSEPH A. 31 ACT FP
PO BOX 247, CALHOUN 30701
BISHOP, LINTON H., JR. 29 ACT IM
490 PEACHTREE ST NE, ATLANTA 30308
BISNO, DAVID C. 16 ACT OPH
33 UPPER RIVERDALE RD, RIVERDALE 30274
BITTLE, CHARLES R. 54 ACT AN
VA MEDICAL CENTER, AUGUSTA 30910
BIVENS, EDWARD S. 29 ACT R
1692 EAST CLIFTON RD NE, ATLANTA 30307
BIVINGS, F. LEE 29 ACT PD
3110 HABERSHAM RD NW, ATLANTA 30309
BIVINS, BLAKE S. 50 ACT FP
404 BEECH ST, COCHRAN 31014
BLACK, GRADY E. 59 ACT PD
567 SOUTH NINTH ST, GRIFFIN 30223
BLACK, JUDSON G. 29 ACT IM
3250 HOWELL MILL RD NW 305, ATLANTA 30327
BLACK, PAUL W. 29 ACT PS
993-C JOHNSON FERRY RD NE, ATLANTA 30342
BLACK, WILEY S. 34 ACT GS
669 LANIER PARK DR NE, GAINESVILLE 30505
BLACKBURN, J.D. 69 ACT ORS
4 IROQUOIS TRAIL, ORMOND BEACH FL 32074
BLACKMAN, WILLIAM M. 76 ACT OPH
1111 PROFESSIONAL BLVD, DALTON 30720
BLACKSHEAR, STUART G. 34 ACT GS
669 LANIER PARK DR NE, GAINESVILLE 30505
BLACKSTON, RONALD D. 22 ACT PD
1365 CLIFTON RD NE, ATLANTA 30322
BLACKWELL, J. THOMAS, JR. 11 ACT AN
515 EAST 63 ST, SAVANNAH 31405
BLACKWELL, JAMES COLLIER 76 ACT IM
1308 MEMORIAL DR, DALTON 30720
BLADOWSKI, JOHN R. 60 ACT OTO
800 EAST DOYLE ST, TOCCOA 30577
BLAINE, B.C. 29 ACT IM
2018 HOLLYWOOD RD NW, ATLANTA 30318
BLAIR, H. DUANE 22 ACT GS
755 COLUMBIA DR STE 919, DECATUR 30030
BLAKE, GREGORY H. 47 S FP
MARTIN ARMY HOSP, FORT BENNING 31905
BLALOCK, C. PHILLIP 06 ACT R
MIDDLE GEORGIA HOSPITAL, MACON 31201
BLALOCK, H. SHERMAN 54 ACT ORS
820 ST SEBASTIAN WAY STE 8, AUGUSTA 30902
BLALOCK, JACK H., JR. 47 ACT IM
2300 MANCHESTER EXPY, F-1, COLUMBUS 31904
BLALOCK, JOHN C. 29 ACT GS
2637 PEACHTREE RD NE APT 110, ATLANTA 30305
BLALOCK, TULLY T. 29 ACT IM
3280 HOWELL MILL RD NW 217, ATLANTA 30327
BLANC, JAMES S. 17 ACT TS
1660 MULKEY RD STE A, AUSTELL 30001
BLANCHARD, HUBERT H. 59 ACT P
BRIGHTMOOR NURSING HOME, GRIFFIN 30223
BLANCHARD, THOMAS W. 54 ACT U
1512 ANTHONY RD, AUGUSTA 30904
BLAND, JAMES W., JR. 29 ACT AN
1405 CLIFTON RD NE, ATLANTA 30322
BLANK, SAMUEL 29 S OS
1670 CLAIRMONT RD NE, DECATUR 30033
BLANK, STEPHEN C. 29 ACT OBG
315 BOULEVARD NE STE 328, ATLANTA 30312
BLEICH, ALLAN C. 29 ACT IM
5669 PEACHTREE-DUNWOODY RD, ATLANTA 30342
BLEICH, J.K. 29 ACT IM
490 PEACHTREE ST, STE 229-B, ATLANTA 30308
BLISSIT, JOSEPH A. 38 ACT IM
175 DECATUR RD, MCDONOUGH 30253
BLITCH, PIERCE G., JR. 54 ACT IM
820 ST SEBASTIAN WAY STE 3-A, AUGUSTA 30902
BLIVEN, FLOYD E., JR. 54 ACT ORS
TALMADGE MEMORIAL HOSPITAL, AUGUSTA 30912
BLOCK, DONALD L. 29 ACT OBG
1175 PEACHTREE ST NE, ATLANTA 30361
BLOODWORTH, A. FREDERICK 34 ACT IM
1098 SOUTH ENOTA DR NE, GAINESVILLE 30505
BLOODWORTH, RONALD C. 29 ACT P
3188 ATLANTA ST SE, SMYRNA 30080

BLOOM, WILLIAM F. 06 ACT R
111 PRESTWICK PK, MACON 31210
BLOUNT, WADE B. 54 ACT OBG
820 ST SEBASTIAN WAY, AUGUSTA 30904
BLUESTEIN, BARRY M. 22 ACT IM
755 COLUMBIA DR, DECATUR 30030
BLUMBERG, MAX M. 29 ACT IM
490 PEACHTREE ST STE 371-C, ATLANTA 30308
BLUMBERG, RICHARO W. 22 R PD
2419 WOODWARD WAY NW, ATLANTA 30305
BLUMENFELO, ALVIN 22 ACT OBG
495 WINN WAY STE B-110, DECATUR 30030
BLUMENTHAL, JEROME B. 17 ACT IM
833 CAMPBELL HILL ST ' 460, MARIETTA 30090
BOATWRIGHT, JERRY A. 24 ACT GP
DRAWER EEE, ST MARYS 31558
BOBO, W. EARL 22 ACT GS
465 WINN WAY STE 201, DECATUR 30030
BOBRAKOV, EREM E. 29 ACT FP
573 WEST PEACHTREE ST NE, ATLANTA 30308
BOOOIE, A.M. 02 ACT FP
240 NORTH WAYNE ST, MILLEDGEVILLE 31061
BODZINER, L.S. 11 ACT OBG
19 MEDICAL ARTS CENTER, SAVANNAH 31405
BOGER, RICHARO E. 29 ACT PD
5675 PEACHTREE-DUNWOODY RD, ATLANTA 30342
BOGER, ROBERT M. 29 S IM
1670 CLAIRMONT RD, DECATUR 30033
BOGGESS, NEIL O., JR. 76 ACT FP
1012 BURLEYSON DR, DALTON 30720
BOHAN, GUNAR N. 22 ACT PH
440 WINN WAY, DECATUR 30030
BOHANAN, G. WAYNE 36 ACT R
102 HOSPITAL DR, WARNER ROBINS 31093
BOHANNON, DONALO S. 11 ACT AN
515 EAST 63RD ST STE 3, SAVANNAH 31405
BOHLER, C. EMORY 08 ACT FP
PO BOX 8, BROOKLET 30415
BOHLER, CLORINOA S. 54 ACT EM
2279 WRIGHTSBORO RD, AUGUSTA 30904
BOHORFOUSH, J.G. 02 R IM
1661 STONEMEADOW RD, MILLEDGEVILLE 31061
BOLCH, SIONEY J. 11 ACT CD
6 ST JOSEPH'S PROF PLAZA, SAVANNAH 31406
BOLING, BARBARA E. 29 ACT IM
3810 PLEASANTDALE RD, ATLANTA 30340
BOLING, JAMES F. 13 ACT IM
FORSYTH COUNTY PARK RD, CUMMING 30130
BONO, ROBERT K. 07 ACT IM
PO BOX E, ELLIJAY 30540
BONDELL, STEVEN P. 29 ACT PTH
340 BOULEVARD NE STE 318, ATLANTA 30312
BONDURANT, H. WILLIAM 29 ACT ORS
478 PEACHTREE ST NE, ATLANTA 30308
BONE, OAVID K. 29 ACT CDS
5669 PEACHTREE DUNWOODY RD, ATLANTA 30342
BONNER, JOHN T. 29 ACT AN
1670 CLAIRMONT RD, DECATUR 30033
BONNER, WILLIAM H. 15 ACT PD
740 PRINCE AVE, ATHENS 30601
BOOKER, DANIEL C., JR 72 ACT ORS,PDS
2002 ALICE ST, WAYCROSS 31501
BOOKOUT, MARK W. 76 ACT OTO
1436 BROADRICK DR, DALTON 30720
BOONE, ARLIE G. 06 I&R FP
784 SPRING ST, MACON 31201
BOOTH, ARTHUR S., JR. 29 ACT GS
993 JOHNSON FERRY RD NE, ATLANTA 30342
BOOTLE, JAMES C. 29 ACT PTH
PO BOX 80846, ATLANTA 30366
BOOTLE, WILLIAM A., JR. 36 ACT R
HOUSTON CO HOSPITAL, WARNER ROBINS 31093
BOOZER, ALBERT MARION 76 ACT FP
1109 BURLEYSON DR, DALTON 30720
BORDERS, JUEL PATE 29 ACT OBG
991 MLK JR DR, ATLANTA 30314
BOROON, JOSE ANTONIO 29 R AN
830 MOUNT VERNON HWY NW, ATLANTA 30327
BOSS, J. LARRY 10 ACT FP
611 NORTH AVE, VILLA RICA 30180
BOSTWICK, JOHN, III 29 ACT PS
25 PRESCOTT ST NE, ATLANTA 30308
BOSWELL, JOHN R. 29 R AN
292 ACADEMY ST, MADISON 30650
BOSWELL, T.C. 14 ACT FP
BOX 156, TATE 30177
BOSWELL, W.C. 65 ACT PD
4246 OLD CLUB RD EAST, MACON 31210
BOTSTEIN, GARY R. 22 ACT IM
2712 NORTH DECATUR RD, DECATUR 30033
BOTTOMS, WILLIAM R. 13 ACT FP
RTE 1 BOX 334, CUMMING 30130
BOUOET, OTONIEL M. 02 ACT GP
HOSP BOX 71 APT 202, MILLEDGEVILLE 31062
BOUSQUET, FRANKLYN P., JR. 11 ACT OPH
2 JACKSON BLVD, SAVANNAH 31405
BOWCOCK, JAMES Z. 22 ACT P
755 COLUMBIA DR STE 418, DECATUR 30030
BOWOEN, RALPH O. 11 ACT GP
22 EAST TAYLOR ST, SAVANNAH 31401
BOWDEN, TALMADGE A., JR. 54 ACT GS
MEDICAL COLLEGE OF GEORGIA, AUGUSTA 30902
BOWEN, ALAN L. 27 ACT ORS
1825 MARTHA BERRY BLVD, ROME 30161
BOWEN, EOWARD G. 29 ACT OBG
960 JOHNSON FERRY RD NE, ATLANTA 30342
BOWEN, JOHN L. 54 DE2 PD
PO BOX 15226, ASHEVILLE NC 28803
BOWEN, ROBERT W. 16 ACT OBG
181 SW UPPER RIVERDALE RD, RIVERDALE 30274
BOWEN, WILLIAM L., JR. 15 ACT OBG
1010 PRINCE AVE, ATHENS 30601
BOWLES, F. NORMAN, JR. 17 ACT PTH
3950 AUSTELL RD, AUSTELL 30001
BOWLES, STEPHEN M. 29 ACT AN
35 LINDEN AVE NE, ATLANTA 30308
BOWMAN, M.B. 23 ACT GS
RTE 3 BOX 594-M, ALBANY 31707
BOWYER, FRANK P. 06 ACT PD
777 HEMLOCK ST, MACON 31201
BOYO, AUGUSTUS B. 15 ACT AN
PO BOX 1732, ATHENS 30601
BOYO, CARL R. 11 ACT GS
#1 MEDICAL ARTS CENTER, SAVANNAH 31405
BOYD, CLAUD A., JR. 54 ACT D
1509 ANTHONY RD, AUGUSTA 30904
BOYO, DONALO L. 23 ACT ORS
1105 PALMYRA RD, ALBANY 31708
BOYD, GLENN H. 76 ACT IM
1203 MEMORIAL DR, DALTON 30720
BOYD, RONALD J. 02 ACT FP
750 NORTH COBB ST, MILLEDGEVILLE 31061
BOYO, WILLIAM S. 54 ACT OBG
1501 WINTER ST, AUGUSTA 30904
BOYETT, JAMES E. 29 ACT TS
1603 WARE AVE, EAST POINT 30344
BOYETTE, D. MORTON 23 ACT OTO
804 14TH AVE, ALBANY 31708
BOYLE, LAWRENCE P. 29 ACT GS
105 COLLIER RD NW, ATLANTA 30309
BOYLE, STEPHEN 48 ACT GS
1359 MILSTEAD RD STE 202, CONYERS 30207
BOYTER, HENRY H. 47 ACT OBG
116 DOCTORS BLDG, COLUMBUS 31901
BRACKETT, J. GORDON 29 ACT OTO
340 BOULEVARD NE, ATLANTA 30312
BRACKETT, MICHAEL L. 47 I&R
PO BOX 951, COLUMBUS 31994
BRACKETT, MORRIS E. 29 R OBG,PH
5505 MOUNT VERNON PKY NW, ATLANTA 30327
BRADBURY, ROBERT G. 11 ACT R
311 EAST HALL ST, SAVANNAH 31401
BRADLEY, CHARLES K. 34 ACT OPH
PO BOX 657, GAINESVILLE 30503
BRAOLEY, PAUL L. 76 ACT GS
PO BOX 1969, DALTON 30720
BRAHN, GEORGE R. 36 ACT GS
105-B BRIARCLIFF, WARNER ROBINS 31093
BRAMBLETT, A.W., JR. 06 R FP
97 CULLODEN RD, FORSYTH 31029
BRAMBLETT, RUPERT H. 13 ACT FP
326 DAHLONEGA RD, CUMMING 30130
BRANAM, JAMES W., JR. 06 ACT P
624 NEW ST, MACON 31201
BRANAN, WILLIAM J., JR. 22 ACT PDA,AL
5040 SNAPFINGER WOODS DR, DECATUR 30035
BRANCH, CLINTON E., JR. 34 ACT N
290 SOUTH ENOTA DR, GAINESVILLE 30501
BRANCH, OAVIO L., JR. 56 ACT ORS
DOCTORS BLDG, VALDOSTA 31602
BRANCH, JOHN L., JR. 17 ACT IM
86 SOUTH COBB DR, MARIETTA 30063
BRANO, ROBERT L. 54 ACT ORS
PO BOX 2806, AUGUSTA 30904
BRANOAU, A. GOROON, JR. 22 ACT IM
LAVISTA PERIMETER OFC PK, TUCKER 30084
BRANOENBURG, OAVIO S. 29 ACT GE
5667 PEACHTREE-DUNWOODY RD, ATLANTA 30342
BRANOON, R.V. 59 ACT FP
WESTBURY MED CARE HOME, JENKINSBURG 30234
BRANDT, HENRY A. 11 ACT P
220 EAST HALL ST, SAVANNAH 31401
BRANNEN, EOMUNO A. 06 R OBG
675 NEW ST, MACON 31201
BRANNEN, J.H. 56 ACT U
401 WOODROW WILSON DR, VALDOSTA 31602
BRANNON, EMMETT S. 27 ACT IM
3 PROFESSIONAL CT, ROME 30161
BRANNON, LAWRENCE T. 22 ACT P
4928 LAVISTA RD, TUCKER 30084
BRANSOME, EOWIN D., JR. 54 ACT IM
MEDICAL COLLEGE OF GEORGIA, AUGUSTA 30912
BRANTLEY, JAMES W. 75 ACT GS
PO BOX 1133, JESUP 31545
BRANTLEY, MARVIN A., III 29 ACT P
1365 CLIFTON RD NE, ATLANTA 30322
BRANYON, OONALD L., JR. 15 ACT OBG
1010 PRINCE AVE, ATHENS 30601
BRASWELL, HAROLO M. 46 S AM
PO BOX 469, CAMILLA 31730
BRASWELL, L. RENOER 29 ACT FP
143 WEST PACES FERRY RD NW, ATLANTA 30305
BRAUN, IRA F. 29 ACT R
1365 CLIFTON RD NE, ATLANTA 30322
BRAWNER, O.L. 11 ACT OBG
PO BOX 22729, SAVANNAH 31403
BRAWNER, JAMES N., III 29 A IM
35 COLLIER RD NW STE 775, ATLANTA 30367
BRECKENRIOGE, H.E., JR. 21 ACT FP
HOSPITAL CIR, DONALSONVILLE 31745
BREEOLOVE, WILLIAM O. 47 I&R
PO BOX 951, COLUMBUS 31994
BRENNAN, CARL H. 11 ACT PD
4 MEDICAL ARTS CENTER, SAVANNAH 31405
BRENNAN, JAMES A. 68 ACT IM
303 SMITH ST, LA GRANGE 30240
BRETT, MILES ELI 17 ACT FP
2550 WINDY HILL RD STE 307, MARIETTA 30067
BREWER, PHILIP L. 47 ACT CDS
201 PHYSICIANS BLDG, COLUMBUS 31901
BREWER, SPENCER S., JR. 29 ACT IM
1938 PEACHTREE RD NW, ATLANTA 30309
BREWSTER, EOWARO W., JR. 27 ACT R
1104 MARTHA BERRY BLVD, ROME 30161
BREWTON, SAMUEL A., JR. 69 ACT U
206 CHEROKEE RD, THOMASTON 30286
BRIANT, THOMAS P. 29 ACT AN
35 COLLIER RD NW STE 560, ATLANTA 30309

BRICE, ANTON, JR. 22 ACT IM
495 WINN WAY STE B-220, DECATUR 30030
BRICE, BOYCE S. 27 ACT GS
HARBIN CLINIC, ROME 30161
BRICKMAN, STANLEY PERRY, DDS 22 AF OS
755 COLUMBIA DR STE A, DECATUR 30030
BRIDGER, CLARENCE E. 23 ACT PTH
PO BOX 1828, ALBANY 31702
BRIDGES, GLENN J. 29 ACT U
573 WEST PEACHTREE ST NE, ATLANTA 30308
BRIDGES, H. BENTON 54 ACT ORS
1138 DRUID PARK AVE, AUGUSTA 30904
BRIDGES, MERCER T. 54 ACT ORS
3623 J DEWEY GRAY CIR #103, AUGUSTA 30909
BRIDGES, WILLIAM H. 23 R R
4501 OLD DAWSON RD, ALBANY 31707
BRIDGES, WILLIAM Z. 65 ACT OPH
808 GORDON AVE, THOMASVILLE 31792
BRIGGS, WILLIAM J., III 50 ACT FP
PO BOX 97, MILAN 31060
BRIGHTWELL, LARRY 47 ACT GS
PO BOX 6829, COLUMBUS 31907
BRIGLEVICH, ROSE M. 17 ACT IM
3903 SOUTH COBB DR STE 207, SMYRNA 30080
BRIGMAN, JAMES A., JR. 29 ACT U
993-F JOHNSON FERRY RD NE, ATLANTA 30342
BRILL, HARRY H., JR. 47 ACT IM
1905-C SEVENTH AVE, COLUMBUS 31901
BRINKLEY, AVERY B. 06 ACT R
312 CANDLER DR, MACON 31204
BRINSFIELD, DOROTHY 29 ACT PDC
EMORY UNIVERSITY CLINIC, ATLANTA 30322
BRINSON, JOHN B., JR. 65 ACT FP
503 GORDON AVE, THOMASVILLE 31792
BRISTER, MARILYN R. 47 I&R FP
PO BOX 951, COLUMBUS 31902
BRISTOL, WILLIAM P. 06 ACT PD
MERCER UNIV SCHOOL OF MEDICINE, MACON 31207
BROCATO, SIMONE 47 ACT CD
ST FRANCIS MEDICAL PK 'F 3, COLUMBUS 31904
BROCK, ROY CRAWFORD 27 ACT GS
14 PROFESSIONAL CT, ROME 30161
BROCK, WILLIAM A. 23 ACT IM
1700 EAST BROAD AVE, ALBANY 31705
BRODERICK, JOHN R. 11 ACT IM
2203 ABERCORN ST, SAVANNAH 31401
BRODY, HAROLD J. 29 ACT D
478 PEACHTREE ST STE 711-A, ATLANTA 30308
BROGDON, JOSEPH M., JR. 06 ACT N
829 FIRST ST, MACON 31201
BROOKS, BETTY ANN 22 ACT OBG
465 WINN WAY STE 100, DECATUR 30030
BROOKS, BETTY SUE 54 ACT DR
MEDICAL COLLEGE OF GEORGIA, AUGUSTA 30912
BROOKS, CHARLES P. 50 ACT FP
PO BOX 35, COCHRAN 31014
BROOKS, COURTNEY CLARK 17 R US
4283 WOODLAND BROOK DR NW, ATLANTA 30339
BROOKS, W. SCOTT, JR. 29 ACT IM
1365 CLIFTON RD NE, ATLANTA 30322
BROOKS, WILLIAM P. 06 ACT FP
3741 HOUSTON AVE, MACON 31201
BROOME, HARRY L. 29 ACT ORS
960 JOHNSON FERRY RD NE, ATLANTA 30342
BROUN, PAUL C., JR. 61 ACT FP
1102 EAST LAMAR ST, AMERICUS 31709
BROWN, ALGIE C. 29 ACT D
817 DOUGLAS RD NE, ATLANTA 30342
BROWN, BEN S. 69 ACT OBG
PO DRAWER 1166, THOMASTON 30286
BROWN, BOBBY C. 29 ACT PTH
1968 PEACHTREE RD NW, ATLANTA 30309
BROWN, CHARLES E. 29 ACT IM
21 EIGHTH ST NE, ATLANTA 30309
BROWN, CHARLES W. 29 ACT ORS
478 PEACHTREE ST NE, ATLANTA 30308
BROWN, DEMPSEY S. 06 ACT GS
380 HOSPITAL DR STE 150, MACON 31201
BROWN, DWIGHT J., JR. 30 ACT OBG
3020 SHRINE RD, BRUNSWICK 31520
BROWN, EDWARD B. 72 ACT OBG
PO BOX 177, WAYCROSS 31501
BROWN, ELBERT H. 36 ACT FP
1015 NORTH HOUSTON RD, WARNER ROBINS 31093
BROWN, GEORGE W. 59 ACT R
686 SOUTH EIGHTH ST, GRIFFIN 30223
BROWN, GROVER J. 04 ACT FP
PO BOX 908, CARTERSVILLE 30120
BROWN, H. EUGENE 29 R IM
622 PARK LN, DECATUR 30033
BROWN, HOWARD S. 29 ACT TS
5669 PEACHTREE-DUNWOODY RD, ATLANTA 30342
BROWN, JAMES A. 54 ACT OPH
3636 WHEELER RD, AUGUSTA 30909
BROWN, JIMMY S. 29 ACT PD
3162 PIEDMONT RD, ATLANTA 30305
BROWN, JOSEPH E. 30 ACT ORS
3208 SHRINE RD, BRUNSWICK 31520
BROWN, LEONARD 17 ACT D
833 CAMPBELL HILL ST ' 260, MARIETTA 30090
BROWN, LESTER A. 29 ACT OTO
490 PEACHTREE ST NE, ATLANTA 30308
BROWN, LUTHER E. 06 ACT OPH
800 FIRST ST, MACON 31201
BROWN, MORRIS E. 29 ACT IM
1372 PEACHTREE ST NE, ATLANTA 30309
BROWN, NELSON H. 29 ACT IM
478 PEACHTREE ST NE, ATLANTA 30308
BROWN, NYDA WILLIAMS 29 ACT P
106 PEACHTREE BATTLE AVE NW, ATLANTA 30305
BROWN, ROBERT H. 29 ACT OTO
3280 HOWELL MILL RD NW, ATLANTA 30327
BROWN, ROBERT L. 29 R GS
321 ROBIN HOOD RD NE, ATLANTA 30309
BROWN, ROLAND A. 06 ACT OBG
306 ORANGE ST, MACON 31201
BROWN, SAMUEL B. 29 ACT P
450 EAST PACES FERRY RD NE, ATLANTA 30305
BROWN, SOLOMON K. 54 ACT R
820 ST SEBASTIAN WAY, AUGUSTA 30902
BROWN, STEPHEN W. 54 ACT R
820 ST SEBASTIAN WAY, AUGUSTA 30902
BROWN, THOMAS D., JR. 34 ACT OTO
304 ENOTA DR NE, GAINESVILLE 30505
BROWN, W. MORRIS, JR. 06 ACT GS
380 HOSPITAL DR C-430, MACON 31201
BROWN, WALTER J., JR. 15 ACT IM
UNIVERSITY HEALTH SERVICE, ATHENS 30602
BROWN, WILBERT O. 11 A
4 PIPEMAKER LN, SAVANNAH 31411
BROWN, WILLIAM M. 17 ACT IM,CD
833 CAMPBELL HILL ST ' 360, MARIETTA 30060
BROWN, WILLIAM O. 19 ACT PTH
COLQUITT CO MEMORIAL HOSP, MOULTRIE 31768
BROWNE, RODNEY M. 06 ACT OBG
380 HOSPITAL DR, MACON 31201
BROWNING, JOHN W. 34 ACT OBG
1211 SHERWOOD PARK DR, GAINESVILLE 30501
BROWNSTEIN, RICHARD E. 23 ACT IM,GE
806 14TH AVE, ALBANY 31701
BRUBAKER, LEONARD H. 54 ACT ON,HEM
MEDICAL COLLEGE OF GEORGIA, AUGUSTA 30912
BRUCE, JAMES F., JR. 68 ACT ORS
301 MEDICAL DR #505, LA GRANGE 30240
BRUCKNER, EVERT A. 29 AF ON
HOSPITAL VOANDES-CASILLA 691, QUITO ECUADOR
BRUCKNER, HOWARD L. 54 ACT OPH
905 15TH ST, AUGUSTA 30902
BRUECKNER, LAWRENCE T. 13 ACT ORS
2121 FOUNTAIN DR STE 500, SNELLVILLE 30278
BRUMLEY, GEORGE W. 29 ACT PD
2040 RIDGEWOOD DR NE, ATLANTA 30322
BRUNER, BARBARA 29 A PD
69 BUTLER ST SE, ATLANTA 30303
BRUNS, WILLIAM L., JR. 54 ACT OBG
1430 HARPER ST, AUGUSTA 30910
BRUNT, GWYNNE T., JR. 29 ACT R,NM
1000 JOHNSON FERRY RD NE, ATLANTA 30342
BRUSMAN, HAROLD P. 16 ACT PTH
33 SW UPPER RIVERDALE RD, RIVERDALE 30274
BRYAN, H. DAVID 22 ACT OBG
2183 NORTHLAKE PKY STE 102, TUCKER 30084
BRYANS, C.I., JR. 54 ACT OBG
TALMADGE MEMORIAL HOSPITAL, AUGUSTA 30912
BRYANT, JAMES M., JR. 20 ACT GP
32 JACKSON ST, NEWNAN 30263
BRYANT, MILTON F. 29 ACT GS
35 COLLIER RD NW, ATLANTA 30309
BUAFO, CHARLES K. 06 ACT CD
770 PINE ST STE 160, MACON 31201
BUCHANAN, L.C. 22 ACT GS
374 WEST PONCE DE LEON AVE, DECATUR 30030
BUCKHAULTS, W.W. 11 ACT OPH
5354 REYNOLDS ST, SAVANNAH 31405
BUCKNER, LESLIE 23 ACT OBG
RTE 3 BOX 446, LEESBURG 31763
BUELVAS, RAUL S. 11 ACT ORS
7 ST JOSEPH PROFESS PLAZA, SAVANNAH 31406
BUKA, NORMAN J. 06 ACT OBG
4717 BRAE BURN LN, MACON 31210
BULLOCK, HUEY G. 54 ACT DR
820 ST SEBASTIAN WAY STE 1-A, AUGUSTA 30901
BUNNEN, ROBERT L., DDS 29 AF GS
3312 PIEDMONT RD NE, ATLANTA 30305
BUNTIN, WILLIAM H. 23 ACT AN
2503 PHEASANT DR, ALBANY 31707
BURBAN, THOMAS 30 ACT IM,EM
221 HERMITAGE WAY, ST SIMONS IS 31522
BURDETTE, FRED M. 47 ACT CDS
201 PHYSICIANS BLDG, COLUMBUS 31901
BURDISON, WILLIAM R. 54 S IM
2410 WILLIAMS ST, AUGUSTA 30904
BURGAMY, CLYDE A. 54 ACT OBG
3614 J DEWEY GRAY CIR STE D, AUGUSTA 30909
BURGE, DAN 29 ACT IM
315 BOULEVARD NE, ATLANTA 30312
BURGESS, RUSSELL E. 54 ACT ON
2101 CENTRAL AVE, AUGUSTA 30904
BURGSTINER, CARSON B. 11 ACT OBG
5354 REYNOLDS ST STE 304, SAVANNAH 31405
BURK, BILLY D. 27 ACT OBG
909 NORTH FIFTH AVE, ROME 30161
BURKE, K. DEAN 06 I&R OBG
BOX 68, MACON 31204
BURLEIGH, BRUCE D. 17 ACT FP
37 MOORE AVE NE, MARIETTA 30060
BURLESON, JAMES W. 22 ACT AN
755 COLUMBIA DR STE 413, DECATUR 30030
BURN, JOHN F. 30 R PD
749 DEER RUN VILLAS, ST SIMONS IS 31522
BURNETT, CLAUDE A., III 15 S OS
468 NORTH MILLEDGE AVE, ATHENS 30601
BURNETT, OMER L., JR. 23 ACT R
PO BOX 1924, ALBANY 31703
BURNETT, STACY W. 22 ACT PD
2100 PARKLAKE DR NE STE 15, ATLANTA 30345
BURNHAM, JAMES W., JR. 06 ACT GP
1923 JEFFERSONVILLE RD, MACON 31201
BURNS, JAMES B. 17 ACT R
737 CHURCH ST, MARIETTA 30061
BURNS, JAMES R., JR. 34 ACT GP
700 SOUTH ENOTA DR NE, GAINESVILLE 30505
BURNS, JOHN A. 34 ACT AN
NE GEORGIA MED CENTER, GAINESVILLE 30501
BURNS, JOHN KNOX, III 34 ACT OBG
1100 VINE ST, GAINESVILLE 30505
BURNS, MATTHEW L. 20 ACT GS
PO BOX 609, NEWNAN 30264

BURNS, R.A. 07 ACT FP
BOX 725, BLUE RIDGE 30513
BURNS, ROBERT A. 76 ACT GS
1109 BURLEYSON DR, DALTON 30720
BURNS, WILLIAM B., JR. 29 ACT IM
35 COLLIER RD NW, ATLANTA 30309
BURR, MAX E. 47 ACT ORS
6262 HAMILTON RD, COLUMBUS 31904
BURRELL, MATTHEW O. 29 ACT ON
5669 PEACHTREE-DUNWOODY RD, ATLANTA 30342
BURRELL, ZEB, JR. 12 ACT IM
46 LAUREL DR, ELBERTON 30635
BURROUGHS, FLEMING 61 ACT IM
PO BOX 1717, AMERICUS 31709
BURSON, E. NAPIER, JR. 29 ACT IM
5669 PEACHTREE-DUNWOODY RD, ATLANTA 30342
BURSON, JOHN H., III 10 ACT OTO
802 DIXIE ST, CARROLLTON 30117
BURTNER, DAVID E. 06 ACT FP
MERCER UNIV SCH OF MEDICINE, MACON 31207
BURTON, CHARLES C. 06 ACT GS
380 HOSPITAL DR STE 150, MACON 31201
BURTON, HERBERT W. 29 R IM
5115 LONG ISLAND DR NW, ATLANTA 30308
BUSBEE, PERRY G. 26 ACT FP
PO BOX 587, CORDELE 31015
BUSBEE, PERRY G., JR. 06 I&R
MEDICAL CENTER OF CENTRAL GA, MACON 31204
BUSEY, T.J. 16 ACT U
225 WEST LANIER AVE, FAYETTEVILLE 30214
BUSEY, THOMAS J., JR. 29 ACT U
2748-B FELTON DR, ATLANTA 30344
BUSH, DWANA M. 29 ACT FP
90 WEST WIEUCA RD, ATLANTA 30342
BUSH, JAMES L. 42 R OPH,OTO
RTE 3 BOX 293, DUBLIN 31021
BUSH, JOHN 47 ACT FP
PO BOX 213, PHENIX CITY AL 36867
BUSH, LEON H. 54 ACT IM
1507 ANTHONY RD, AUGUSTA 30904
BUSSEY, JOHN R. 29 ACT EM
48 INMAN CIR NE, ATLANTA 30309
BUSSEY, JOSEPH G., JR. 32 ACT GS
5990 LOVE ST, AUSTELL 30001
BUTLER, AORIENNE B. 72 ACT PD
307 PINEVIEW DR, WAYCROSS 31501
BUTLER, CHARLES W., JR. 29 ACT OBG
5675 PEACHTREE-DUNWOODY RD, ATLANTA 30342
BUTLER, CLARENCE 47 ACT IM
PO BOX 7000, COLUMBUS 31995
BUTLER, ELIZABETH O. 29 I&R IM
792 MARSTEVAN DR, ATLANTA 30306
BUTLER, JACK A. 50 ACT FP
PO BOX 666, UNADILLA 31091
BUTLER, JOHN E. 72 ACT GS
1508 TEBEAU ST, WAYCROSS 31501
BUTLER, RICHARD H. 29 S AM
1048-B NORTH JAMESTOWN RD, DECATUR 30033
BUTLER, WALTER H. 29 ACT AN
35 COLLIER RD NW STE 560, ATLANTA 30309
BUTT, JAVED A. 76 ACT IM
1217 MEMORIAL DR, DALTON 30720
BUTTERFIELD, ARTHUR E. 31 ACT OBG
PO BOX 667, CALHOUN 30701
BUTTERWORTH, H. HARPER 22 ACT IM
DISABILITY DETERMINATION UN, DECATUR 30030
BUTTS, JAMES A. 34 ACT IM
710 BROAD ST SE, GAINESVILLE 30501
BUXTON, HUBERT, JR. 06 ACT AN
4928 GUERRY DR, MACON 31204
BYARS, STEVENS 68 ACT PH
406 COUNTRY CLUB RD, LA GRANGE 30240
BYARS, WILLIAM P., JR. 54 ACT OBG
3614 J DEWEY GRAY CIR STE D, AUGUSTA 30909
BYERS, KATHLEEN 29 R AN
396 WIMBLEDON RD NE, ATLANTA 30324
BYERS, KENNETH W. 31 ACT IM
2 HOSPITAL CT, CALHOUN 30701
BYNE, J.M., JR. 09 ACT IM
205 SEVENTH ST, WAYNESBORO 30830
BYRD, JEFF W. 65 ACT PTH
JD ARCHBOLD MEM HOSPITAL, THOMASVILLE 31792
BYRD, M. DANIEL 29 ACT IM
340 BOULEVARD NE, ATLANTA 30312
BYRNES, WILLIAM F. 29 ACT AN
2760-B FELTON DR, EAST POINT 30344
BYTELL, DAVID E. 54 ACT ORS
1511 ANTHONY RD, AUGUSTA 30904

C

CABANISS, W. HARVEY, JR. 15 ACT D
1010 PRINCE AVE, ATHENS 30601
CABASARES, HORATIO V. 36 ACT GS
1057 MORNINGSIDE DR, PERRY 31069
CABEZAS, RODRIGO 29 ACT TS,CDS
5669 PEACHTREE-DUNWOODY RD, ATLANTA 30342
CABOT, ANTHONY 17 ACT ORS
3903 SOUTH COBB DR STE 101, SMYRNA 30080
CABOT, WILLIAM 17 ACT ORS
3903 SOUTH COBB DR STE 101, SMYRNA 30080
CABRERA, LORENZO 17 ACT OBG
3903 SOUTH COBB DR #206, SMYRNA 30080
CABRERA-CICERO, ORLANOO 42 S GS
VA CENTER, DUBLIN 31021
CACCHIOLI, LOUIS G. 35 ACT FP
202 WEST HOWELL ST, HARTWELL 30643
CADIER, THOMAS R. 29 ACT ORS
4555 NORTH SHALLOWFORD RD, DUNWOODY 30338
CAIN, ROBERT T. 65 ACT FP
PO BOX 231, QUITMAN 31643
CALDWELL, CRAIG 06 ACT IM
90 CULLODEN RD, FORSYTH 31029
CALOWELL, JOSEPH L., JR. 54 ACT GS
808 13TH ST, AUGUSTA 30901
CALHOUN, A. DOUGLAS 23 ACT GS
801 - 13TH AVE, ALBANY 31701
CALHOUN, CHARLES L. 47 ACT OPH
PO BOX 4276, COLUMBUS 31995
CALHOUN, CLARENCE 23 ACT GS
PO BOX 2031, ALBANY 31702
CALHOUN, CLYDE R., JR. 29 ACT OBG
993-D JOHNSON FERRY RD, ATLANTA 30342
CALHOUN, F.P., JR. 29 ACT OPH
25 PRESCOTT ST NE, ATLANTA 30308
CALHOUN, W.C. 72 ACT OBS
PO BOX 1945, WAYCROSS 31501
CALLAHAN, DAN 36 ACT
134 HOSPITAL DR, WARNER ROBINS 31093
CALLAHAN, WILLIAM THOMAS 34 ACT GE
710 BROAD ST SE, GAINESVILLE 30501
CALLAWAY, GEORGE M., JR. 29 S IM
1670 CLAIRMONT RD NE, DECATUR 30033
CAMBLOR, GONZALO 17 ACT PTH
COBB GENERAL HOSPITAL, AUSTELL 30001
CAMERON, E. CHRISTIAN 29 ACT IM
3280 HOWELL MILL RD NW, ATLANTA 30327
CAMP, LEAH R. 47 ACT PH
PO BOX 2299, COLUMBUS 31993
CAMPA, JOSE C. 56 ACT ORS
2704 OAK ST BLDG B-3, VALDOSTA 31602
CAMPBELL, CLARENCE G., JR 42 ACT R
PO BOX 793, DUBLIN 31021
CAMPBELL, DAVID G. 29 ACT OPH
1365 CLIFTON RD NE, ATLANTA 30322
CAMPBELL, DONALD H. 17 ACT GS
757 HAMPTON PL, MARIETTA 30064
CAMPBELL, HAROLD EUGENE 12 R FP
46 LAUREL AVE, ELBERTON 30635
CAMPBELL, JAMES A. 05 ACT IM
PO BOX 1107, FITZGERALD 31750
CAMPBELL, ROBERT D. 61 ACT FP
1102 EAST LAMAR ST, AMERICUS 31709
CAMPBELL, WALLACE G. 29 ACT PTH
EMORY UNIV SCHOOL OF MED, ATLANTA 30322
CAMPO, M. LEONAROO 08 ACT IM
130 NORTH GRAY ST, MILLEN 30442
CANKIR, KAMIL S. 20 ACT GP
PO BOX D, GRANTVILLE 30220
CANNON, CLIFTON L., JR. 11 ACT NS
4 JACKSON BLVD, SAVANNAH 31405
CANTWELL, JOHN OAVIS 29 ACT CD
300 BOULEVARD NE, ATLANTA 30312
CAPLAN, DANIEL B. 29 ACT PD
2040 RIDGEWOOD DR NE, ATLANTA 30322
CAPLAN, GERALD E. 11 ACT R
PO BOX 23089, SAVANNAH 31403
CAPPARELL, ROBERT 29 ACT ID
993-D JOHNSON FERRY RD, ATLANTA 30342
CAPUTO, RAYMOND V. 29 ACT D
960 JOHNSON FERRY RD STE 450, ATLANTA 30342
CARABAJAL, NESTOR R. 29 ACT CDS
5669 PEACHTREE-DUNWOODY RD, ATLANTA 30342
CARAS, THOMAS S. 17 ACT IM
641 CHURCH ST STE B, MARIETTA 30060
CARBAUGH, ROBERT G. 72 ACT AN
1908 ALICE ST, WAYCROSS 31501
CAROOSO, DAVID 02 ACT OBG
PO BOX 489, MILLEDGEVILLE 31062
CARGILL, LOUIS H. 23 ACT GP
1009 NORTH MONROE STE 102, ALBANY 31701
CARICO, JAMES M. 65 ACT R
PO BOX 736, THOMASVILLE 31792
CARLAN, STEPHEN J. 69 ACT OBG
PO DRAWER 1166, THOMASTON 30286
CARLIN, RICHARD 13 ACT OPH
2347 LENORA CHURCH RD, SNELLVILLE 30278
CARLISLE, O.B. 29 ACT OPH
3169 MAPLE DR NE, ATLANTA 30305
CARLOCK, KELLER S. 29 ACT PD
3162 PIEDMONT RD NE, ATLANTA 30305
CARLTON, FRANK E. 11 ACT U
2515 HABERSHAM ST, SAVANNAH 31499
CARMAN, JOHN SCOTT 17 ACT P
3188 ATLANTA ST, SMYRNA 30080
CARPENTER, HARRIS DEITZ, JR. 06 ACT U
770 PINE ST STE 520, MACON 31201
CARPENTER, PAUL R. 65 ACT DR
113 WEST HANSELL ST, THOMASVILLE 31792
CARPENTER, R.S. 56 ACT GS
2533 NORTH ASHLEY, VALDOSTA 31602
CARPENTER, ROBERT H. 47 ACT OBG
2404 13TH ST, COLUMBUS 31906
CARR, ALBERT A. 54 ACT IM
MEDICAL COLLEGE OF GEORGIA, AUGUSTA 30902
CARR, DANIEL J. 29 ACT IM
105 COLLIER RD NW STE 4080, ATLANTA 30309
CARR, J. BRUCE 47 ACT NEP
2300 MANCHESTER EXPY, COLUMBUS 31904
CARR, RICHARD D. 29 S PM
3744 PREAKNESS DR, DECATUR 30034
CARRINGTON, KENNETH W. 54 ACT NS
820 ST SEBASTIAN WAY, AUGUSTA 30902
CARROLL, CHERYL A. 47 ACT NPM
1968 NORTH AVE, COLUMBUS 31995
CARROLL, H. BANKS 47 ACT FP
2100 NORTH AVENUE, COLUMBUS 31904
CARROLL, M. SCOTT 29 ACT A
6667 VERNON WOODS DR NE, ATLANTA 30328
CARROLL, ROBERT R. 23 ACT IM,HEM
500 THIRD AVE STE 109, ALBANY 31701
CARRUTH, JOSEPH E. 42 ACT CD,IM
606 ACADEMY AVE, DUBLIN 31021
CARSON, J. DAVID 22 ACT EM
2701 NORTH DECATUR RD, DECATUR 30033
CARSON, JAMES MAXWELL 29 ACT IM
340 BOULEVARD NE, ATLANTA 30312

CARSON, LARRY V. 54 ACT NS
MEDICAL COLLEGE OF GEORGIA, AUGUSTA 30912
CARSON, W.P. 76 ACT GS
PO BOX 129, DALTON 30720
CARSPECKEN, H. HUTSON 22 ACT PS
500 IRVIN CT STE C-250, DECATUR 30030
CARSWELL, AUGUSTIN S. 54 ACT ORS
3623 J DEWEY GRAY CIR ' 201, AUGUSTA 30909
CARSWELL, NELSON S., JR. 42 ACT PD
MEDICAL ARTS CENTER, DUBLIN 31021
CARTER, A.W., JR. 29 ACT FP
4932 PHILLIPS DR, FOREST PARK 30050
CARTER, CURTIS H. 54 ACT IM
748 AUMOND RD, AUGUSTA 30909
CARTER, DAVID K. 23 ACT EM
PO BOX 1828, ALBANY 31703
CARTER, JACK W., JR. 54 ST
MEDICAL COLLEGE OF GEORGIA, AUGUSTA 30912
CARTER, JAMES A. 29 ACT OTO
35 COLLIER RD NW, ATLANTA 30309
CARTER, JOHN LEROY, JR. 22 ACT OBG
5 PERIMETER OFFICE PK, TUCKER 30084
CARTER, LEON, JR. 22 ACT FP
465 WINN WAY STE 231, DECATUR 30030
CARTER, M. GARY 06 ACT OPH
1818 FORSYTH ST CROSSTOWN 75, MACON 31201
CARTER, MARY JO 54 ACT IM
MEDICAL COLLEGE OF GEORGIA, AUGUSTA 30912
CARTER, MICHAEL P. 11 ACT R
5223 PAULSEN ST, SAVANNAH 31405
CARTER, OTHA B., JR. 23 ACT GS
801 - 13TH AVE, ALBANY 31701
CARTER, RICHARD F. 68 ACT IM,GE
CLARK HOLDER CLINIC, LAGRANGE 30240
CARTER, ROBERT A. 36 ACT GP
PO BOX 2201, WARNER ROBINS 31093
CARTER, ROBERT GLENN 62 ACT IM
303 FRASER DR, HINESVILLE 31313
CARTER, ROBERT H. 11 ACT GS
4920 PAULSEN ST, SAVANNAH 31405
CARTER, ROY G. 29 ACT P
340 BOULEVARD STE 307, ATLANTA 30312
CARTER, SANDY B. 29 R IM
355 LONDONBERRY RD NW, ATLANTA 30327
CARTER, SANOY B., JR. 29 ACT IM
6500 VERNON WOODS DR NE, ATLANTA 30328
CARTER, STEPHEN L. 22 ACT
7660 COVINGTON HWY, LITHONIA 30058
CARTER, YANCEY FRANKLIN 66 ACT GP
1223 EAST MCPHERSON, NASHVILLE 31639
CASARELLA, WILLIAM J. 29 ACT R
1364 CLIFTON RD, ATLANTA 30322
CASH, TEO D. 70 ACT FP
PO BOX 48, CHICKAMAUGA 30707
CASKIN, CLINTON R.J., JR. 15 ACT U
245 WESTVIEW DR, ATHENS 30601
CASSIDY, BRUCE A. 29 ACT IM
105 COLLIER RD NW STE 2040, ATLANTA 30309
CASTILLO, REUBEN 16 ACT FP
217 ARROWHEAD BLVD, JONESBORO 30236
CASTLE, JOHN R. 22 ACT OBG
235 EAST PONCE DE LEON, DECATUR 30030
CASTRESANA, MANUEL R. 06 ACT AN
777 HEMLOCK ST, MACON 31208
CATALANO, PHILIP W. 54 ACT GS
2100 CENTRAL AVE STE 5, AUGUSTA 30904
CATANZARO, MARSHALL J. 29 ACT R
1000 JOHNSON FERRY RD NE, ATLANTA 30342
CATES, ROBERT M. 27 ACT OBG
10 HOSPITAL CIR, ROME 30161
CATO, ROBERT E. 06 R R
770 PINE ST STE 250, MACON 31201
CAUBLE, GEORGE 17 ACT FP
4803 MAIN ST, ACWORTH 30101
CAUBLE, JOHN A. 14 ACT FP
PO BOX 1048, CANTON 30114

CAUDILL, DARRELL R. 29 ACT TS
315 BOULEVARD NE STE 528, ATLANTA 30312
CAUSEY, DAVID A. 43 ACT R
LUMPKIN COUNTY HOSPITAL, DAHLONEGA 30533
CAUSEY, ROBERT S., JR. 17 ACT PD
122 CHERRY ST, MARIETTA 30060
CAUTHEN, LARRY R. 27 ACT AN
13 JOHN MADDOX DR, ROME 30161
CAVANAGH, HARRISON D. 29 ACT OS
1365 CLIFTON RD NE, ATLANTA 30322
CEBULA, JEROME M. 48 R PTH
2537 HIGHLAND DR, CONYERS 30207
CELAYA, CARLOS L. 17 ACT U
3903 SOUTH COBB DR STE 212, SMYRNA 30080
CELESTINO, FRANK S. 47 DE4 FP
MARTIN ARMY HOSPITAL, FORT BENNING 31905
CELIS, RODOLFO 68 ACT R
PO BOX 1348, LA GRANGE 30241
CENIZA, SILVERIO A., JR. 50 ACT GS
116 LUMPKIN ST, HAWKINSVILLE 31036
CENTER, A.H. 11 ACT P
10 MEDICAL ARTS CENTER, SAVANNAH 31405
CERTAIN, MARSHA J. 29 I&R IM
80 BUTLER ST SE, ATLANTA 30303
CHAIT, DONALD C. 29 ACT IM,HEM
478 PEACHTREE ST NE, ATLANTA 30308
CHALMERS, RIVES 29 ACT P
2905 PEACHTREE RD NE, ATLANTA 30305
CHAMBERLAIN, CHARLES R., JR. 54 ACT PTH
VA MEDICAL CENTER, AUGUSTA 30904
CHAMBERS, BENJAMIN M. 29 ACT OPH
490 PEACHTREE ST STE 242-B, ATLANTA 30308
CHAMBERS, DONN A. 29 ACT AN
5665 PEACHTREE DUNWOODY RD, ATLANTA 30342
CHAMBERS, ROY G. 54 ACT P
820 ST SEBASTIAN WAY STE 3-D, AUGUSTA 30902
CHAMBLESS, MIRIAM WALKER 45 ACT FP
PO BOX 345, HAMILTON 31811
CHAMBLESS, WILLIAM G. 45 R FP
PO BOX 345, HAMILTON 31811
CHANDLEE, ROBERT E. 17 ACT R
3865 STORY DR SW, MARIETTA 30060
CHANDLER, A. BLEAKLEY 54 ACT PTH
MEDICAL COLLEGE OF GEORGIA, AUGUSTA 30912
CHANDLER, NEAL W. 29 ACT DR
4680 RIVERVIEW RD NW, ATLANTA 30327
CHANEY, RALPH H., JR. 30 ACT AN
3226 HAMPTON AVE, BRUNSWICK 31520
CHANG, PAUL K. 02 A P
CENTRAL STATE HOSPITAL, MILLEDGEVILLE 31062
CHAO, STEPHEN C. 46 ACT OBG
16606 PARK LANE PL, LOS ANGELES CA 90049
CHAO, YU-CHIA 28 ACT FP
350 CHURCH ST, ROYSTON 30662
CHAPMAN, RODGER W. 29 ACT EM,IM
340 BOULEVARD NE #135, ATLANTA 30312
CHAPPELL, AMEY 29 ACT IM
3750 PEACHTREE ST NE, ATLANTA 30319
CHASE, JERRY S. 47 ACT FP
2121 WARM SPRINGS RD, COLUMBUS 31995
CHASTAIN, GEORGE M. 23 ACT AN
2614 RIDGEWOOD LN, ALBANY 31707
CHASTAIN, J.B. 47 ACT PD
1710 HILTON AVE, COLUMBUS 31906
CHAUDHARY, BASHIR AHMAD 54 ACT IM
MEDICAL COLLEGE OF GEORGIA, AUGUSTA 30912
CHEATHAM, JAMES S. 17 ACT P
3188 ATLANTA ST, SMYRNA 30080
CHELTON, ALICE G. 29 ACT P
1970 CLIFF VALLEY WAY NE, ATLANTA 30329
CHELTON, L. GUY 29 ACT IM
755 COLUMBIA DR STE 302, DECATUR 30030
CHELTON, LOUIS G., III 13 ACT EM
PO BOX 98, LAWRENCEVILLE 30247
CHEN, GUEY-CHING LAI 16 ACT GP
6670 MERCHANTS WAY, MORROW 30260

CHEN, YEE C. 16 ACT ORS
6670 MERCHANTS WAY, MORROW 30260
CHENEY, HUDDIE L. 65 ACT IM
PO BOX 1099, THOMASVILLE 31792
CHENG, YUEH Y. 61 ACT PD
PO BOX 485, AMERICUS 31709
CHENG, YUNG-SHENG 11 ACT OBG
5420 PAULSEN ST, SAVANNAH 31405
CHERNECKY, RICHARD E. 13 ACT IM
719 SCENIC HWY STE D, LAWRENCEVILLE 30245
CHEVES, H.L. 29 ACT FP
2726-B FELTON DR, EAST POINT 30344
CHEVRES, FRANK, MD FACS 16 ACT ORS
113 UPPER RIVERDALE RD, RIVERDALE 30274
CHEWNING, RICHARD D. 59 ACT OBG
503 SOUTH EIGHTH ST, GRIFFIN 30223
CHHOKAR, BALBIR S. 47 ACT OPH
711 CENTER ST, COLUMBUS 31904
CHHOKAR, RAJINDER 47 ACT IM,CD
711 CENTER ST, COLUMBUS 31901
CHIANG, MIKE S. 66 ACT U
1615 JOHN ORR DR, TIFTON 31794
CHIPMAN, R.A. 47 ACT FP
PHYSICIANS BLDG, COLUMBUS 31901
CHISHOLM, LEWIS F. 56 ACT FP
305 WEST PLANT AVE, HOMERVILLE 31634
CHISM, NEWTON W., JR. 42 ACT OBG
ERIN OFFICE PARK, DUBLIN 31021
CHOI, SUN IK 68 ACT AN
801 CHEROKEE RD, LA GRANGE 30240
CHOI, USUP 23 ACT ORS
1909 ABERDEEN RD, ALBANY 31701
CHORCHES, MICHAEL A. 29 ACT CD
5665 PEACHTREE-DUNWOODY RD, ATLANTA 30342
CHOTINER, GERALD 29 ACT D
3250 HOWELL MILL RD NW, ATLANTA 30327
CHRISTENSEN, EUNICE H. 65 R AN
PO BOX 1096, THOMASVILLE 31792
CHRISTIAN, J.O., JR. 54 ACT ORS
1521 ANTHONY RD (10), AUGUSTA 30910
CHRISTMAS, JOSEPH T. 26 ACT FP
VIENNA 31092
CHRISTMAS, ROBERT C. 17 ACT OBG
STE F, MARIETTA 30060
CHRISTY, JAMES H. 29 ACT IM
1365 CLIFTON RD NE, ATLANTA 30322
CHUBB, NICHOLAS CARROLL 54 ACT P
4212 DUNWOODY RD, MARTINEZ 30907
CHUNG, SOONG PYO 42 ACT PTH
VA CENTER, DUBLIN 31021
CHURCH, JOHN C. 76 ACT DR
PO BOX 2339, DALTON 30720
CIBIK, GEORGE M. 29 ACT IM,GE
3250 HOWELL MILL RD NW, ATLANTA 30327
CIOFFI, CYRUS M. 29 ACT R
315 BOULEVARD NE, ATLANTA 30312
CITRON, JOSEPH 29 ACT OPH
571 WEST PEACHTREE ST NW, ATLANTA 30308
CLAIBORNE, T. STERLING 29 ACT IM
455 WEST WESLEY RD NW, ATLANTA 30305
CLAIBORNE, THOMAS S., JR. 29 ACT IM,GE
35 COLLIER RD NW STE 650, ATLANTA 30309
CLAIR, ALVIN H. 29 ACT D
777 CLEVELAND AVE #500, ATLANTA 30315
CLAIRMONT, ALBERT A. 29 ACT OTO
25 PRESCOTT ST NE STE 6404, ATLANTA 30308
CLARK, ALAN D. 29 ACT GP,EM

CLARK, EUGENE 23 ACT NEP
507 THIRD AVE, ALBANY 31701
CLARK, JAMES E. 29 ACT IM
35 COLLIER RD NW, ATLANTA 30309
CLARK, NEWTON T., JR. 29 ACT ORS
993 JOHNSON FERRY RD NE, ATLANTA 30342
CLARK, NILE R. 15 ACT FP
1160 PRINCE AVE, ATHENS 30601

CLARK, REMER Y., JR. 17 ACT FP
754 CHEROKEE ST, MARIETTA 30060
CLARK, ROBERT B., JR. 57 ACT GP,GS
PO BOX 367, VIDALIA 30474
CLARK, S. WILLIAM, JR. 72 ACT OPH
PO BOX 2009, WAYCROSS 31501
CLARK, SARAH L. 54 ACT IM
3623 J DEWEY GRAY CIR ' 308, AUGUSTA 30909
CLARK, TERESA E. 29 ACT IM
490 PEACHTREE ST NE, ATLANTA 30308
CLARK, WILLIAM L., JR. 54 ACT ORS
820 ST SEBASTIAN WAY STE 8, AUGUSTA 30902
CLARKE, GEORGE O. 11 ACT AN
18 MAGNOLIA XING, SAVANNAH 31411
CLARY, THOMAS L., JR. 54 R IM
712 OBERLIN RD, AUGUSTA 30909
CLARY, W. UPTON 11 ACT NS
4 JACKSON BLVD, SAVANNAH 31405
CLARY, WILLIAM A. 11 ACT N
4 JACKSON BLVD, SAVANNAH 31499
CLAY, HENRY T. 06 ACT FP
1640 COLEMAN AVE, MACON 31201
CLAY, JAMES R. 15 ACT PTH
ATHENS GENERAL HOSPITAL, ATHENS 30613
CLAYTON, EDWARD C. 02 ACT R
BOX 231, IRWINTON 31042
CLAYTON, MAX L. 11 ACT AN
8 STEPHENSON AVE, SAVANNAH 31405
CLECKLEY, HERVEY M. 54 ACT P
820 ST SEBASTIAN STE 3-D, AUGUSTA 30902
CLEMENTS, FREO N. 66 ACT FP
807 NORTH PARRISH AVE, ADEL 31620
CLEMENTS, J.L., JR. 29 ACT R
80 BUTLER ST SE, ATLANTA 30303
CLEMENTS, LARRY V. 17 ACT PD
833 CAMPBELL HILL ST #112, MARIETTA 30090
CLEMENTS, STEPHEN D. 29 ACT CD
1365 CLIFTON RD NE, ATLANTA 30322
CLEMONS, THURMAN 08 ACT GP
PO BOX 821, STATESBORO 30458
CLEPPER, ALAN S. 47 ACT PTH
PO BOX 4176, COLUMBUS 31902
CLINE, STEVEN G. 29 ACT R
1170 CLEVELAND AVE, EAST POINT 30344
CLINKSCALES, GRADY S., JR. 29 ACT ORS
3707 TUXEDO RD NW, ATLANTA 30305
CLONTS, W.T. 17 ACT R
70 TOWER RD, MARIETTA 30061
CLOUSE, JOHN E., JR. 59 ACT FP
655 BROOK CIR, GRIFFIN 30223
COAN, MARK G. 29 ACT GS
4536 CHAMBLEE-DUNWOODY RD, ATLANTA 30338
COATES, GRAHAM 23 ACT P
1112 NORTH MADISON, ALBANY 31705
COBB, CLAUD P., JR. 29 R FP
201 ANGELA CT, STOCKBRIDGE 30281
COBB, ELLIOTT A. 11 R ORS
20 EAST 52ND ST, SAVANNAH 31405
COBBS, B. WOODFIN, JR. 29 ACT IM
1365 CLIFTON RD NE, ATLANTA 30322
COCHRAN, E.B. 17 ACT GS
641 CHURCH ST, MARIETTA 30060
COCHRAN, J. SYDNEY 21 ACT IM,PD
PO BOX 385, BAINBRIDGE 31717
COCHRAN, T.A. 70 ACT FP
1215 CLEARVIEW DR, RINGGOLD 30736
COCHRAN, THOMAS A., JR. 47 ACT PS
2200 NORTH AVE, COLUMBUS 31904
CODE, REDMOND L.D. 29 I&R R
804 SUMMIT NORTH, ATLANTA 30324
CODINGTON, ARTHUR B. 22 ACT IM
542 CHURCH ST RM 232, DECATUR 30030
COE, H.M. 30 ACT ORS
1120 PALMETTO AVE, BRUNSWICK 31520
COFFSKY, JAY S. 22 ACT R
755 COLUMBIA DR STE 205, DECATUR 30030
COGGINS, ROBERT P. 17 ACT IM
787 CAMPBELL HILL ST, MARIETTA 30060
COHEN, DAVID M. 29 ACT OTO
993 JOHNSON FERRY RD NE, ATLANTA 30342
COHEN, I.R. 29 ACT PD
1285 PEACHTREE ST NE STE 127, ATLANTA 30309
COHEN, JACK H. 29 ACT GS
4553 N SHALLOWFORD RD 40-B, ATLANTA 30338
COHEN, LARRY A. 15 ACT R
1 HUNTCLIFF WAY, ATHENS 30606
COHEN, LAWRENCE 16 ACT OBG
33 SW UPPER RIVERDALE RD, RIVERDALE 30274
COHEN, LOUIS V. 06 ACT FP
3225 PIO NONO AVE, MACON 31206
COHEN, MARVYN D. 47 ACT PD,AL
1968 NORTH AVE, COLUMBUS 31901
COHEN, MICHAEL JOSEPH 54 ACT RHU
1109 MEDICAL CENTER DR, AUGUSTA 30909
COHEN, PAUL G. 29 ACT IM
993 JOHNSON FERRY RD NE, ATLANTA 30342
COHEN, RICHARD W. 17 ACT ORS
1620 MULKEY RD-UPPER LEVEL, AUSTELL 30001
COHEN, ROBERT A. 29 ACT IM
2030 PERNOSHAL CT STE D, ATLANTA 30338
COHEN, SHELDON B. 29 ACT P
490 PEACHTREE ST NE, ATLANTA 30308
COHENOUR, JEFFREY H. 71 ACT PTH
PO BOX 946, MONROE 30655
COHN, MARVIN H. 29 ACT IM
1372 PEACHTREE ST NE, ATLANTA 30309
COHN, PERRY L. 06 ACT NS
770 PINE ST STE 500, MACON 31201
COLDITZ, RICHARD B. 10 ACT OBG
305 TANNER ST, CARROLLTON 30117
COLEMAN, BLANCHE D. 54 ACT OBG
1450 ANTHONY RD, AUGUSTA 30904
COLEMAN, FRANCIS W. 56 ACT IM
501 WOODROW WILSON DR, VALDOSTA 31602
COLEMAN, FRED J. 42 R FP
1616 BELLEVUE RD, DUBLIN 31021
COLEMAN, JOHN J., III 29 ACT ON
1365 CLIFTON RD NE, ATLANTA 30322
COLEMAN, OTHA K. 26 ACT FP
115 WEST 13TH AVE, CORDELE 31015
COLEMAN, REESE C., JR. 29 R U
1328 DOROTHY DR, CLEARWATER FL 33546
COLEMAN, W.E. 50 ACT FP
PO BOX 469, HAWKINSVILLE 31036
COLEMAN, WILLIAM M. 23 ACT ORS
1136 DAWSON RD, ALBANY 31707
COLES, W.C. 29 R R
2606 PIEDMONT RD NE, ATLANTA 30324
COLIER, HOWARD J. 32 ACT ORS
1001 ATLANTA W BLVD, LITHIA SPRINGS 30057
COLLENTINE, THOMAS A. 29 ACT EM
5288 HUNTINGFORD CT, MARIETTA 30062
COLLIER, HAL F. 29 ACT R
960 JOHNSON FERRY RD NE, ATLANTA 30342
COLLIER, M. OWAYNE 27 ACT U
321 TURNER MCCALL BLVD, ROME 30161
COLLINS, BRASWELL E. 06 ACT OPH
2635 STANISLAUS CIR, MACON 31204
COLLINS, CHAPPELL A., JR. 23 ACT FP
810 13TH AVE, ALBANY 31701
COLLINS, DAVID R. 14 ACT IM
110 WALESKA RD, CANTON 30114
COLLINS, JAMES E. 45 ACT FP
129 EAST SECOND ST, MANCHESTER 31816
COLLINS, JOHN T. 27 ACT OBG
316 WEST TENTH ST, ROME 30161
COLLINS, LEWIS R. 20 ACT IM
PO BOX 609, NEWNAN 30263
COLLINS, MYRON D.F. 54 ACT ORS
PO BOX 2806, AUGUSTA 30904
COLLINS, WILLIAM C. 29 ACT ORS
993 JOHNSON FERRY RD NE, ATLANTA 30342
COLLINS, WILLIAM T., JR. 22 ACT FP
1462 MONTREAL RD STE 212, TUCKER 30084
COLMERS, RUDOLF A. 11 ACT CD,IM
5354 REYNOLDS ST STE 222, SAVANNAH 31405
COLON, LUIS M. 02 ACT OBG
CENTRAL STATE HOSPITAL, MILLEDGEVILLE 31061
COLQUITT, ALFRED O., III 17 ACT ORS
211 CHICOPEE DR, MARIETTA 30060
COLQUITT, ALFRED O., JR. 17 ACT OBG
615 ROSWELL ST, MARIETTA 30060
COLQUITT, HUGH S. 17 ACT PD
615 ROSWELL ST, MARIETTA 30060
COLVIN, RICHARD S. 22 ACT R
1365 CLIFTON RD NE, ATLANTA 30322
COLVIN, WILLIAM S. 59 ACT PD
666 SOUTH EIGHTH ST, GRIFFIN 30223
COMSTOCK, THOMAS W. 29 ACT OTO
3280 HOWELL MILL RD NW, ATLANTA 30327
CONE, TERRY A. 47 I&R
PO BOX 951, COLUMBUS 31994
CONESCU, PAUL V. 22 ACT ORS
487 WINN WAY STE 101, DECATUR 30030
CONGER, A.B. 47 ACT GS
206 DOCTORS BLDG, COLUMBUS 31901
CONGER, P.D. 19 ACT FP
15 FIFTH AVE SW, MOULTRIE 31768
CONKLIN, HARVEY B. 11 ACT EM,GS
5278 HWY 80, GARDEN CITY 31408
CONN, LEE R.M. 47 ACT GP
1305 FOREST AVE, COLUMBUS 31906
CONNELL, DON R. 08 ACT R
500 EAST GRADY ST, STATESBORO 30458
CONNELL, H.R., JR. 27 ACT OPH
HARBIN CLINIC, ROME 30161
CONNELLY, JOHN C. 47 ACT P
2000 16TH AVE, COLUMBUS 31993
CONNER, GEORGE R. 47 ACT GP
920 - 18TH ST, COLUMBUS 31993
CONNER, H.I. 57 ACT GS
PO BOX 1107, VIDALIA 30474
CONNER, WILLIAM C. 13 ACT P
PO BOX 427, SNELLVILLE 30278
CONOLEY, KENNETH 60 ACT PD
800 EAST DOYLE ST, TOCCOA 30577
CONRAD, CONSTANCE C. 29 A PM
PO BOX 23604, ATLANTA 30322
COOK, ERNEST L. 54 ACT P
PO BOX 3718, AUGUSTA 30904
COOK, JOHN R. 54 ACT D
EISENHOWER ARMY MED CTR, FORT GORDON 30905
COOK, RONALO N. 29 ACT IM
490 PEACHTREE ST NE #567-C, ATLANTA 30308
COOK, TERRENCE J. 54 ACT IM
2042 CENTRAL AVE, AUGUSTA 30904
COOK, WILLIAM C., JR. 29 ACT AN
3113 FARMINGTON DR NE, ATLANTA 30339
COOLEDGE, JOHN W. 29 A PD
4770 NORTH PEACHTREE RD, ATLANTA 30338
COOLEY, SARAH F. 22 ACT PTH
3644-B CHAMBLEE TUCKER RD, CHAMBLEE 30341
COOPER, CLAIRE V. 15 ACT P
PO BOX 8046, ATHENS 30603
COOPER, EUGENE A. 17 ACT FP
737 CHURCH ST, MARIETTA 30060
COOPER, FLOYD C., III 59 ACT P
324 SOUTH 12TH ST, GRIFFIN 30223
COOPER, FLOYD R., JR. 29 ACT NS
2718 FELTON DR, EAST POINT 30344
COOPER, GERALD R. 29 S PTH
1600 CLIFTON RD NE, ATLANTA 30333
COOPER, J. THOMAS 17 ACT FP
1234 POWERS FERRY RD #102, MARIETTA 30067
COOPER, JERRY D. 29 ACT NEP
35 COLLIER RD NW STE 775, ATLANTA 30367
COOPER, JERRY L. 22 ACT D
495 WINN WAY STE 230-B, DECATUR 30030

COOPER, LAWRENCE E. 29 ACT IM
2550 WINOY HILL RD STE 210, MARIETTA 30067
COPE, DOUGLAS O. 08 ACT OPH
PO BOX 1067, STATESBORO 30458
COPELAN, ELTON L. 60 ACT OBG
PO BOX 788, TOCCOA 30577
COPELAND, FRANK M., JR. 29 ACT P
3280 HOWELL MILL RD STE 109, ATLANTA 30327
COPELAND, LANNY R. 19 ACT FP
PO BOX 2307, MOULTRIE 31768
COPELAND, ROBERT B. 68 ACT CO
1550 OOCTORS DR STE 301, LA GRANGE 30241
COPLIN, PAUL R. 06 ACT P
624 NEW ST, MACON 31201
COPPAGE, TAYLOR 06 ACT OBG
380 HOSPITAL OR STE 320, MACON 31201
COPPAGE, WILLIAM M. 22 ACT AN
755 COLUMBIA OR STE 413, OECATUR 30030
COPPEDGE, W.W. 29 ACT OBG
1702 CLEVELANO AVE, EAST POINT 30344
CORKER, FRANK T. 56 ACT OM
2704 NORTH OAK ST BLDG N, VALOOSTA 31602
CORLEY, C.C. 29 ACT IM,HEM
110 OOWNSHIRE LN, OECATUR 30033
CORNWELL, WILLIAM O. 70 ACT FP
2007 OLD LAFAYETTE RD, FT OGLETHORPE 30742
CORPE, R.F. 27 ACT GS
417 MOUNT ALTO RO, ROME 30161
CORR, J. PRICE, JR. 23 ACT GS
806 14TH AVE, ALBANY 31701
CORSO, J. ARTURO 29 ACT CD
1100 CLEVELAND AVE #200, EAST POINT 30344
CORTES, JULIO P. 29 ACT AN
353 PARKWAY DR NE, ATLANTA 30312
COSTA, CONRAOO V., JR. 11 ACT FP
PO BOX 294, RINCON 31326
COSTANTINO, MARK J. 15 ACT GS
1010 PRINCE AVE, ATHENS 30601
COSTRINI, ANTHONY M. 11 ACT IM,PUO
11706 MERCY BLVO, SAVANNAH 31408
COSTRINI, NICHOLAS V. 11 ACT IM,GE
911 EAST 67TH ST, SAVANNAH 31405
COTTS, LEONARD L. 29 ACT IM
4536 CHAMBLEE OUNWOOOY RO, ATLANTA 30338
COURSON, HERMAN C. 65 ACT IM
PO BOX 1939, THOMASVILLE 31792
COUSINS, ALBERT L. 68 ACT IM
1550 OOCTORS OR STE 301, LA GRANGE 30241
COUSINS, WILLIAM L. 17 ACT IM
166 VANN ST, MARIETTA 30090
COVERT, GEORGE K. 22 ACT GP
PO BOX 1445, STONE MOUNTAIN 30086
COWART, G. THOMAS 29 ACT U
384 PEACHTREE ST NE, ATLANTA 30308
COWGILL, ROBERT 29 ACT ON
5669 PEACHTREE OUNWOODY RD, ATLANTA 30342
COX, CHARLOTTE T. 06 ACT OBG
380 HOSPITAL OR, MACON 31201
COX, OANIEL BAKER 72 ACT IM
2005-C PIONEER ST, WAYCROSS 31501
COX, GEORGE W. 29 ACT DR
5665 PEACHTREE-OUNWOOOY RO, ATLANTA 30342
COX, JOEL E. 59 ACT OBG
503 SOUTH EIGHTH ST, GRIFFIN 30223
CRAFTS, BRYAN C. 29 ACT AN
1000 JOHNSON FERRY RO NE, ATLANTA 30342
CRAIG, JAMES B. 02 ACT P
316 TERRELL DR, MILLEOGEVILLE 31061
CRANK, R. PAUL, JR. 22 ACT IM
1462 MONTREAL RO STE 312, TUCKER 30084
CRANMAN, JERARD S. 22 ACT IM
1275 MCCONNELL DR, OECATUR 30033
CRARY, ELY J. 17 ACT OPH
3903 SOUTH COBB OR, SMYRNA 30080
CRAVER, JOE M. 29 ACT TS
1365 CLIFTON RO NE, ATLANTA 30322
CRAWFORO, CARL L. 36 ACT FP
1410 RUSSELL PKY, WARNER ROBINS 31056
CRAWFORD, CLYDE L. 29 ACT GS
652 WEST PEACHTREE ST NW, ATLANTA 30308
CRAWFORD, JOHN B. 59 ACT FP
10 MARKET ST, BARNESVILLE 30204
CRAWLEY, WILLIAM D. 70 ACT OBG
787 CHICKAMAUGA AVE, ROSSVILLE 30741
CREAGH, GERARO B. 15 ACT PH
555 MILLEDGE CIR, ATHENS 30601
CREECH, EARL L. 56 ACT ORS
PO BOX 3117, VALOOSTA 31601
CREEL, JAMES H. 70 ACT EM
TRI-COUNTY HOSPITAL, FT OGLETHORPE 30742
CREWS, EUGENE L., III 29 ACT P
3188 ATLANTA ST SE, SMYRNA 30080
CREWS, THOMAS L. 48 ACT IM
4140 TATE ST NE, COVINGTON 30209
CRIDER, HARRY J., JR. 29 ACT OBG
303 PILGRIM MILL RD, CUMMING 30130
CRIMMINS, L.T. 23 ACT GS
1111 PALMYRA RO, ALBANY 31701
CRISPIN, ROY H. 22 ACT TS
465 WINN WAY STE 211, DECATUR 30030
CROFT, BARBARA N. 29 ACT OBG
1938 PEACHTREE RO STE 100, ATLANTA 30309
CROFT, THOMAS J. 29 ACT NS
2718 FELTON OR, EAST POINT 30344
CRONCE, PAUL C. 29 ACT D
3316 PIEDMONT RD NE STE 250, ATLANTA 30305
CROOMS, C.L. 29 ACT ORS
960 JOHNSON FERRY RD NE, ATLANTA 30342
CROSBY, WILLIAM V. 15 ACT OBG
740 PRINCE AVE, ATHENS 30601
CROSS, G. LEE, III 29 ACT ORS
340 BOULEVARO NE STE 540, ATLANTA 30312
CROSS, JAMES L. 29 ACT OBG
993-D JOHNSON FERRY RD NE, ATLANTA 30342
CROSS, ROBERT N. 29 ACT R
960 JOHNSON FERRY RD NE, ATLANTA 30342
CROSSE, JAMES E.W. 47 S U
MARTIN ARMY COMM HOSPITAL, FT BENNING 31905
CROUCH, MICKEY M. 54 DE2 FP
MEOICAL COLLEGE OF GEORGIA, AUGUSTA 30902
CROW, ROBERT W. 29 ACT PS
1938 PEACHTREE RD STE 208, ATLANTA 30309
CROWDER, JACKSON G. 47 ACT IM
PHYSICIANS BLOG, COLUMBUS 31901
CROWDIS, JAMES H., JR. 58 ACT GP
PO BOX 547, BLAKELY 31723
CROWE, WILLIAM R. 29 ACT IM
940 FERNCLIFF RO NE, ATLANTA 30324
CRUISE, JOE S. 29 ACT PUO
2491 PACES FERRY RO STE 205, SMYRNA 30080
CRUMBLEY, A.J., JR. 29 ACT GS
2788 BAYARO ST, EAST POINT 30344
CRUMP, HOYT W. 28 ACT FP,EM
350 CHURCH ST, ROYSTON 30662
CRUTCHER, JAMES C. 29 S IM
1011 RIVERBENO CLUB DR, ATLANTA 30339
CRYMES, JOHN M. 15 ACT AN
108 VALLEYWOOO OR, ATHENS 30606
CUCHER, BOBB G. 29 ACT IM
993 JOHNSON FERRY RD NE, ATLANTA 30342
CUFF, JOHN V. 15 ACT NS
1010 PRINCE AVE, ATHENS 30606
CULBRETH, ERNEST W. 27 ACT FP
525 EAST 11TH ST, ROME 30161
CULVERN, ROBERT S. 36 ACT OBG
100 DONNA KAY DR, BONAIRE 31005
CUMMINGS, T.E. 27 ACT FP
HOGUE AVE, ROCKMART 30153
CUNANAN, LINDA C. 20 ACT IM
72 GREENVILLE ST #7, NEWNAN 30263
CUNDEY, DAVID W. 54 ACT CD
1003 CHAFEE AVE, AUGUSTA 30902
CUNOEY, PAUL E., JR. 54 ACT IM
1003 CHAFEE AVE, AUGUSTA 30904
CUNNINGHAM, ROBERT P. 29 ACT IM
675 WEST PEACHTREE ST NE, ATLANTA 30308
CURL, WALTON W. 47 ACT ORS
6262 HAMILTON RO, COLUMBUS 31995
CURLING, PATRICK E. 29 ACT OS
1364 CLIFTON RO NE, ATLANTA 30322
CURRY, LEON E. 08 ACT GP
PO BOX 538, METTER 30439
CURRY, ROBERT H. 29 A PO
69 BUTLER ST SE, ATLANTA 30303
CURRY, SIONEY S. 29 ACT O
3320 HOLCOMB BRIDGE RD, NORCROSS 30092
CURTIS, EARNEST M., JR. 29 ACT OBG
960 JOHNSON FERRY RD NE, ATLANTA 30342
CURTIS, JOHN R. 15 ACT P
UNIVERSITY HEALTH SERVICES, ATHENS 30602
CURTIS, THOMAS H. 70 ACT OBG
744 MCCALLIE AVE, CHATTANOOGA TN 37402
CURTIS, WALKER L. 29 ACT IM
PO BOX 87100, COLLEGE PARK 30337
CUTTINO, JUDSON P. 11 ACT AN
8 STEPHENSON AVE, SAVANNAH 31406
CUTTONE, JAMES M. 48 ACT OPH
1309 MILSTEAO RD, CONYERS 30207
CUTTS, WILLIAM G., JR. 14 ACT GS
651 SHOAL CREEK RD, CANTON 30114

D

D'AUBERMONT, PETER C.S. 29 ACT D
5667 PEACHTREE-OUNWOODY RD, ATLANTA 30342
DAILY, F. WILLSON 11 ACT AN
3 COUNTRY CLUB DR, SAVANNAH 31410
OAITCH, RONALD 54 ACT OBG
9 BENT TREE CT, AUGUSTA 30909
DALAL, SURINDER P.S. 06 ACT IM,PUD
770 PINE ST STE 460, MACON 31201
DALLAS, R.E. 69 ACT FP
PROFESSIONAL BLOG, THOMASTON 30286
OALLAS, WILLIAM M., JR. 69 ACT GS
405 WEST MAIN ST, THOMASTON 30286
DALRYMPLE, DAVID E. 29 ACT IM
6500 VERNON WOOOS OR NE, ATLANTA 30328
DALY, FRANK T., JR. 22 ACT R
755 COLUMBIA DR STE 205, OECATUR 30030
OAMPOG, ALFONSO T. 13 ACT AN
6179 WINOSONG WAY, STONE MOUNTAIN 30087
OANEMAN, E.A. 72 ACT US
2609 PLANT AVE, WAYCROSS 31501
OANESHVAR, BAHMAN 02 ACT IM,HEM
750 NORTH COBB ST, MILLEOGEVILLE 31061
DANIEL, A.B. 08 ACT GS
PO BOX 592, STATESBORO 30458
DANIEL, ERNEST F., JR. 54 ACT NS
3623 J OEWEY GRAY CIR ' 310, AUGUSTA 30909
DANIEL, J.W., JR. 06 ACT FP
1383 OGLETHORPE ST, MACON 31201
DANIEL, JAMES S. 17 ACT PUD
833 CAMPBELL HILL ST ' 200, MARIETTA 30090
DANIELL, OUREN 42 ACT ORS
PO BOX 1687, DUBLIN 31040
DANZIG, LAMONT EARL 11 ACT IM
PO BOX 15238, SAVANNAH 31416
DARDEN, JOHN W. 34 ACT GS
669 LANIER PARK OR NE, GAINESVILLE 30505
DAROEN, WILLIAM ABNER, JR. 11 ACT GS
200 EAST 31ST ST, SAVANNAH 31499
DAROIN, M. VICTOR 76 ACT OBG
PO BOX 989, OALTON 30720
DARNELL, D.T. 14 ACT FP
TATE 30177
DARUGAR, B. BARRY 49 ACT GS
PO ORAWER 760, EATONTON 31024

DASHER, MARION N., JR. 54 ACT GE
820 ST SEBASTIAN WAY, AUGUSTA 30902
DASHER, WILLIAM B., JR. 06 ACT ORS
380 HOSPITAL DR, MACON 31201
DASHIELL, WAVERLEY B. 47 ACT OBG
2039 TENTH AVE, COLUMBUS 31901
DAVENPORT, T.F. 29 ACT PD
1038 PEACHTREE BATTLE AVE NW, ATLANTA 30327
OAVIDSON, CHARLES W. 22 ACT IM
755 COLUMBIA DR STE 713, DECATUR 30030
DAVIDSON, EUGENE D. 29 ACT GS
5669 PEACHTREE-DUNWOODY RD, ATLANTA 30342
DAVIDSON, GENE G. 27 ACT IM
7 JOHN MADDOX DR, ROME 30161
DAVIDSON, JOHN A. 29 ACT OPH
3280 HOWELL MILL RD STE 319, ATLANTA 30327
DAVIDSON, JOHN K., III 29 ACT IM
69 BUTLER ST SE, ATLANTA 30303
DAVIES, NICHOLAS E. 29 ACT IM
35 COLLIER RD NW, ATLANTA 30309
DAVIES, ROBERT L. 22 ACT R
755 COLUMBIA DR STE 205, DECATUR 30030
DAVIS, ALFRED L., JR. 72 ACT PD
1406 TEBEAU ST, WAYCROSS 31501
DAVIS, BILLY J. 35 ACT FP
GIBSON ST, HARTWELL 30643
DAVIS, BYRON S. 56 ACT PTH
PO BOX 2658, VALDOSTA 31602
DAVIS, CURTIS L. 29 S GP
215 LAKEWOOD WAY, ATLANTA 30315
DAVIS, DAVE M. 29 ACT P
1938 PEACHTREE RD NW STE 401, ATLANTA 30309
DAVIS, DONALD C. 22 ACT IM
1365 CLIFTON RD NE, ATLANTA 30322
OAVIS, F. MORRIS 66 ACT FP
820 TIFT AVE, TIFTON 31794
OAVIS, FLOYO E. 72 ACT FP
1921 ALICE ST 1-B, WAYCROSS 31501
DAVIS, GUY C., JR. 29 ACT AN
35 LINDEN AVE, ATLANTA 30365
DAVIS, H.G., JR. 79 ACT FP
PO BOX 405, SYLVESTER 31791
DAVIS, HARRY N. 14 ACT FP
110 WALESKA RD, CANTON 30114
DAVIS, JAMES B. 54 ACT R
PO BOX 10106, AUGUSTA 30903
DAVIS, JEFFREY C. 54 ST
MEDICAL COLLEGE OF GEORGIA, AUGUSTA 30912
DAVIS, JOHN L., III 29 ACT OPH
3250 HOWELL MILL RD NW, ATLANTA 30327
DAVIS, LAWRENCE P. 66 ACT GS
875 LAKESHORE DR, DULUTH 30136
DAVIS, LAWTON C. 42 ACT IM
606 ACADEMY AVE, DUBLIN 31021
DAVIS, LEO J. 23 ACT OTO
804 14TH AVE, ALBANY 31708
DAVIS, M. BEDFORD, JR. 29 ACT GS
340 BOULEVARD NE, ATLANTA 30312
DAVIS, MARK S. 22 ACT OBG
755 COLUMBIA DR STE 702, DECATUR 30030
DAVIS, MARVIN L. 29 ACT PD
5675 PEACHTREE-DUNWOODY RD, ATLANTA 30342
DAVIS, MATTHEW E. 16 ACT OTO
33 SW UPPER RIVERDALE RD, RIVERDALE 30274
OAVIS, PATRICIA C. 29 ACT R
1365 CLIFTON RD NE, ATLANTA 30322
DAVIS, PAUL L., JR. 15 ACT DR
445 WEST CLOVERHURST AVE, ATHENS 30606
DAVIS, R. CARTER, JR. 29 ACT IM,GE
25 PRESCOTT ST NE STE 5404, ATLANTA 30365
DAVIS, ROBERT S. 29 ACT OBG
2100 PARKLAKE DR NE, ATLANTA 30345
DAVIS, S. CARTER, JR. 29 ACT IM
1365 CLIFTON RD NE, ATLANTA 30322
DAVIS, T. ALBERT 56 ACT P
PO BOX 3135, VALDOSTA 31601
DAVIS, TERRELL L. 60 ACT PD
PO BOX 1284, CLAYTON 30525
DAVIS, W. BEN 29 R PD
2065 WALKER AVE, COLLEGE PARK 30337
DAVIS, WILKES H., JR. 17 ACT OPH
653 CHEROKEE ST NE, MARIETTA 30060
DAVIS, WILLIAM A., III 29 ACT R
35 LINDEN AVE NE, ATLANTA 30308
DAVIS, WILLIAM S. 27 ACT P
PO BOX 6206, ROME 30163
DAVIS, WILLIAM S. 17 ACT OBG
#5A, AUSTELL 30001
DAWS, ANTHONY WAYNE 60 ACT GS
FALLS RD PROF PARK, TOCCOA 30577
DAWSON, HARRY E., JR. 27 ACT PS
HARBIN CLINIC, ROME 30161
OAWSON, JACK E., JR. 29 ACT CD
478 PEACHTREE ST NE, ATLANTA 30309
DAWSON, VIRGIL L. 47 I&R
PO BOX 951, COLUMBUS 31994
OAY, JAMES O., III 59 ACT IM
231 GRAEFE ST, GRIFFIN 30223
DE BRA, DON W., JR. 22 ACT END
2712 NORTH DECATUR RD, DECATUR 30033
OE LA PERRIERE, ARMAND 29 ACT OBG
3604 CHAMBLEE TUCKER RD, CHAMBLEE 30341
DE LAOSA, MARIO O. 02 ACT GS
1005 RIVERBEND RD, MILLEDGEVILLE 31061
DE LEMOS, GASTON P. 17 ACT P
833 CAMPBELL HILL ST NE, MARIETTA 30090
DEAL, ALBERT M. 08 ACT GS
PO BOX 647, STATESBORO 30458
OEAL, DAVEY R. 06 ACT GE
724 HEMLOCK ST, MACON 31201
DEAL, HELEN R. 08 R PD
PO BOX 647, STATESBORO 30458
DEAL, WILLIAM R. 08 ACT GS
DONEHOO ST, STATESBORO 30458
OEANORADE, J. ROBIN 29 ACT ORS
69 BUTLER ST, ATLANTA 30303
DEAS, RALPH H. 29 ACT OPH
3166 MAPLE DR NE, ATLANTA 30305
DEATON, BURRELL H. 22 ACT D
4303 LAVISTA RD, TUCKER 30084
DEATON, J.H. 47 ACT R
2868 NANCY ST, COLUMBUS 31906
DEDONIS, JAMES L. 34 ACT IM,CD
667 LANIER PARK DR, GAINESVILLE 30501
DEEN, JOHNNY T. 69 ACT OPH
230 CHEROKEE RD, THOMASTON 30286
OEES, HOYT C. 29 ACT OBG
20 LINDEN AVE NE STE 7-C, ATLANTA 30365
OEGANIAN, JAVAD 13 ACT PD
2121 FOUNTAIN DR STE 200, SNELLVILLE 30278
OEGENHART, WILLIAM J. 11 ACT OPH
5354 REYNOLDS ST, SAVANNAH 31405
DEHAVEN, JOSEPH W. 11 ACT END,IM
40 MEDICAL ARTS CENTER, SAVANNAH 31405
DEITCH, MILTON J. 29 ACT U
960 JOHNSON FERRY RD NE, ATLANTA 30342
DEJARNETTE, ROBERT H., JR. 57 ACT GS
702 MEADOWS LN, VIDALIA 30474
DEKLE, JOHN L., JR. 11 ACT OBG
5212 PAULSEN ST, SAVANNAH 31405
DEL MAZO, JACINTO 29 ACT IM,GE
490 PEACHTREE ST STE 268-C, ATLANTA 30308
DEL PORTILLO, LORENZO A. 02 ACT P
PO BOX 507, HARDWICK 31034
DEL RIO, GABRIEL G. 11 ACT PD
3914 PONCE DE LEON, CORAL GABLES FL 33134
DELANCY, HERMAN 11 ACT GS
5102 PAULSEN ST, SAVANNAH 31405
DELASHMUTT, ROBERT E. 29 ACT PTH
340 BOULEVARD NE, ATLANTA 30312
DELATORRE, JOSE M. 02 ACT P
153 RIVERSIDE DR, MILLEDGEVILLE 31061
DELEVETT, ALLEN F. 30 ACT IM
520 OCEAN BLVD, ST SIMONS IS 31522
DELGADO, ABELARDO R. 02 ACT P
CENTRAL STATE HOSPITAL, MILLEDGEVILLE 31062
DELGADO, EMILIO 53 ACT GS
303 JOHNSON ST, DAWSON 31742
DELGADO, JOSE A. 02 ACT P
107 GARRETT WAY, NW, MILLEDGEVILLE 31061
DELGADO, MERCEOES L. 13 ACT GP
4653 FITZPATRICK WAY, NORCROSS 30092
DELLINGER, RAIDEN W. 27 R GS
702 RIVER AVE, ROME 30161
DELLINGER, RAY E. 17 ACT GS
3001 SOUTH COBB DR SE, SMYRNA 30080
DELOACH, ERVIN D. 11 ACT PS,MFS
515 EAST 63RD ST, SAVANNAH 31405
DEMPSEY, JAMES E. 15 ACT OTO
1010 PRINCE AVE, ATHENS 30601
OENMARK, L.O. 29 ACT PD
5605 GLENRIDGE DR NE, ATLANTA 30342
DENNARD, JAMES E. 56 ACT OTO
DOCTORS BLDG STE 108, VALDOSTA 31602
DENNEY, ROY L. 10 R OTO
130 WEST CLUB DR, CARROLLTON 30117
DENNIS, ALLEN J., JR. 54 ACT IM
TALMADGE MEMORIAL HOSPITAL, AUGUSTA 30912
DENNIS, BROWN W. 29 ACT IM
35 COLLIER RD NW, ATLANTA 30309
DENNIS, DONALD P. 29 ACT OTO,OS
3280 HOWELL MILL RD STE 304, ATLANTA 30327
DENNISON, DAVID B. 29 ACT IM
3280 HOWELL MILL RD NW, ATLANTA 30327
DENNISON, DAVID R.M. 29 ACT IM
3280 HOWELL MILL RD STE 217, ATLANTA 30327
OENSLER, JAMES F. 29 ACT PDS
319 WEST LAKE AVE, ATLANTA 30318
DEREBAIL, GOPALAKRISHNA 06 ACT EM
5021 OXFORD RD, MACON 31210
OERISO, H. CLARK 11 ACT ORS
44 MEDICAL ARTS CENTER, SAVANNAH 31405
DERRICK, BOB L. 29 ACT GS
5669 PEACHTREE-DUNWOODY RD, ATLANTA 30342
DERRICK, HOWARD C., JR. 70 ACT FP
201 SOUTH MAIN ST, LAFAYETTE 30728
DESAI, USHA P. 17 ACT OBG
1660 MULKEY RD STE D, AUSTELL 30001
DESIMONE, JOHN W. 60 ACT FP
800 EAST DOYLE ST, TOCCOA 30577
DEUTSCH, ANTHONY J. 15 ACT IM
700 OGLETHORPE AVE, ATHENS 30606
OEVORE, MARGARET B. 54 ACT AN
MEDICAL COLLEGE OF GEORGIA, AUGUSTA 30912
DEW, J. HARRIS 29 ACT GS
1293 PEACHTREE ST NE, ATLANTA 30309
DEWBERRY, JAMES W. 11 ACT ORS
7 ST JOSEPH'S PROF PLAZA, SAVANNAH 31406
DHARAMSI, MOHAMED N. 48 ACT OBG
1315 MILSTEAD RD, CONYERS 30207
DI BENEDETTO, ROBERT J. 11 ACT IM,PUD
PO BOX 15238, SAVANNAH 31416
DI CRISTINA, MICHAEL A. 59 ACT IM
571 SOUTH NINTH ST, GRIFFIN 30223
DIAL, WILLIAM B. 72 ACT ORS
2002 ALICE ST, WAYCROSS 31501
DIAZ, EVELIO F. 02 ACT P
905 RIVERBEND DR, MILLEDGEVILLE 31061
DICKEY, L.E., JR. 06 R ORS
PO BOX 4504, MACON 31208
DICKINSON, JOHN I. 27 ACT GS
310 WEST SIXTH ST, ROME 30161
DICKINSON, RICHARD F. 23 R R
407 BAY SHORE, PANAMA CITY FL 32407
DICKS, ROBERT E., III 15 ACT NS
1010 PRINCE AVE, ATHENS 30606
DICKSON, WILLIAM A. 56 ACT FP
PO BOX 608, HAHIRA 31632

DIJAMCO, ALICE L. 56 ACT AN
5675 PEACHTREE-DUNWOODY RD, ATLANTA 30342
DILLE, MICHAEL B. 29 ACT R
960 JOHNSON FERRY RD NE, ATLANTA 30342
DILLDN, ROBERT G. 22 ACT IM
2054-B LAWRENCEVILLE HWY, DECATUR 30033
DIMON, JOSEPH H., III 54 ACT ORS
105 COLLIER RD NW STE 5000, ATLANTA 30309
DIMDND, KEITH A. 11 ACT NEP,IM
PO BOX 15238, SAVANNAH 31416
DINNERSTEIN, ALLAN J. 16 ACT OBG
29 SW UPPER RIVERDALE RD, RIVERDALE 30274
DINDLOV, JORDAN V. 26 ACT FP
PO BOX 232, ASHBURN 31714
DISANTIS, DENNIS E. 22 ACT GE
487 WINN WAY STE 206, DECATUR 30030
DISMUKE, JAMES C. 66 ACT FP
PO BOX 307, ADEL 31620
DIVINE, RICHARD D. 29 ACT OS
2004 PEACHTREE RD NW, ATLANTA 30367
DIXDN, A.V., JR. 23 ACT CHP
514 FOURTH AVE, ALBANY 31701
DIXDN, JIMMY L. 30 ACT PS
3215 SHRINE RD, BRUNSWICK 31520
DIXON, JOHN M. 23 ACT OPH
1909 ABERDEEN RD STE 108, ALBANY 31701
DIXON, P.K. 34 ACT GS
669 LANIER PARK DR NE, GAINESVILLE 30505
DIXDN, PIERCE K., III 34 ACT GS
669 LANIER PARK DR, GAINESVILLE 30505
DIXON, SAMMIE 66 ACT OBG
PO BOX 1647, TIFTON 31794
DIZDN, CAYETANO T. 06 ACT AN
777 HEMLOCK ST, MACON 31208
DOAN, TERRENCE B. 29 ACT GS
993 JOHNSON FERRY RD NE, ATLANTA 30342
DOBES, WILLIAM L., JR. 29 ACT D
478 PEACHTREE ST NE, ATLANTA 30308
DODD, JOHN S., JR. 29 ACT IM
35 COLLIER RD NW, ATLANTA 30309
DODD, WILLIAM ASA 42 ACT FP
PO BOX 257, WRIGHTSVILLE 31096
DODGEN, CHARLES WAYNE 69 ACT FP
212 CHEROKEE RD, THOMASTON 30286
DDERR, JAMES L. 68 ACT GS
303 SMITH ST, LA GRANGE 30240
DOHRMANN, DAVID M. 27 ACT PD
16 HOSPITAL CIR, ROME 30161
DDLAN, JDSEPH A. 68 ACT OBG
303 MEDICAL DR, LA GRANGE 30240
DOMESCIK, GERALD 29 ACT R,NR
3200 HOWELL MILL RD NW, ATLANTA 30327
DOMINGOS, WILLIAM R. 06 ACT PUD
187 PIERCE DR, MACON 31204
DDMM, ALBERT C. 10 ACT PTH
311 WEST EIGHTH ST, ROME 30161
DONAGHY, GEORGE E. 47 R US
127 PALO VERDE DR, LEESBURG FL 32748
DDNNELLY, EDWIN H. 29 ACT OPH
3280 HOWELL MILL RD NW, ATLANTA 30327
DDNNELLY, ELWIN W. 29 ACT DR
300 BOULEVARD NE, ATLANTA 30312
DONNER, ROBERT S. 06 ACT PTH
PO BOX 6000, MACON 31208
DOOLEY, WILLIAM D. 27 ACT R
PO BOX 2625, ROME 30161
DORMINEY, HENRY C., JR. 66 ACT AL
1409-B TIFT AVE, TIFTON 31794
DDRMINY, JOHN H., III 66 ACT OBG
PO BOX 1628, TIFTON 31794
DDRNEY, EDWARD R. 29 ACT CD
EMORY UNIVERSITY CLINIC, ATLANTA 30322
DDRSEY, HARRY N. 23 ACT IM
PO BOX 288, ALBANY 31702
DOSS, MELVIN C. 60 ACT FP
800 EAST DOYLE ST, TOCCOA 30577

DOUD, FDRREST J. 48 ACT PD
1233 SALEM GATE WAY, CONYERS 30208
DOUGLAS, BEVERLY G. 29 ACT OBG
1938 PEACHTREE RD NW, ATLANTA 30309
DOUGLAS, JDHN S., JR. 22 ACT CD
1365 CLIFTON RD, ATLANTA 30322
DOUGLASS, THOMAS G. 30 ACT IM
PO BOX 1026, SEA ISLAND 31561
DDVE, DONALD V. 13 R FP
PO BOX 310, GRAYSON 30221
DOWDA, F. WILLIAM 29 ACT IM
490 PEACHTREE ST NE, ATLANTA 30308
DDWLING, GEORGE B. 29 ACT IM
2600 HOWELL MILL RD NW, ATLANTA 30327
DOWMAN, CHARLES E. 29 ACT NS
2965 SOUTH PHARR CT NW, ATLANTA 30305
DOWMAN, CDRDELIA K. 29 ACT PD
2965 SOUTH PHARR CT NW, ATLANTA 30305
DDWNEY, W.P. 10 ACT OM
49 HEAD AVE, TALLAPOOSA 30176
DDWNING, EDWARD F. 11 ACT NS
4 JACKSON BLVD, SAVANNAH 31405
DOXEY, CLEM M., JR. 17 ACT D
114 CHERRY ST 'E, MARIETTA 30090
DOYLE, JOSEPH P., JR. 46 ACT FP
PO BOX 520, CRAWFORDVILLE FL 32327
DOZIER, DOUGLAS P. 06 ACT GE
770 PINE ST STE 550, MACON 31201
DOZIER, FRED A 17 ACT OS
2550 WINDY HILL RD STE 202, MARIETTA 30067
DRAGALIN, DANIEL 29 ACT PD
1375 MIDDLESEX AVE NE, ATLANTA 30306
DRAKE, CHARLES E. 11 ACT IM,CD
100 PARK AVE EAST, SAVANNAH 31401
DRAKE, CHARLES H. 57 ACT FP
707 EAST MARIETTA ST, GLENNVILLE 30427
DRAKE, HENRY C. 16 ACT FP
805 SUMMIT NORTH DR, ATLANTA 30324
DRESSLER, MARIDN S. 22 ACT P
785 HOUSTON MILL RD NE APT 2, ATLANTA 30329
DRUMMOND, JDHN A. 29 ACT IM,ID
35 COLLIER RD NW STE 425, ATLANTA 30309
DRURY, WILEY L. 56 ACT AN
PO BOX 1727, VALDOSTA 31602
DUANE, LAWRENCE, JR. 72 ACT R
PO BOX 938, WAYCROSS 31501
DUARTE, RAMDN RDSA 54 ACT NEP
MEDICAL COLLEGE OF GEORGIA, AUGUSTA 30912
DUBDIS, RICHARD E. 29 ACT IM
478 PEACHTREE ST STE 207-A, ATLANTA 30308
DUBOSE, BDLLING S., JR. 15 ACT IM
225 SOUTH MILLEDGE, ATHENS 30601
DUBDSE, DAVID M. 29 ACT IM
6500 VERNON WOODS DR NE, ATLANTA 30328
DUBOSE, LIGE MDULTRIE 17 ACT OPH
833 CAMPBELL HILL ST #380, MARIETTA 30090
DUDLEY, A.B., JR. 47 ACT IM
711 CENTER ST, COLUMBUS 31901
DUDLEY, A.G. 61 ACT OBG
401 SOUTH LEE ST, AMERICUS 31709
DUDLEY, JAMES C. 61 ACT GS
629 EAST FORSYTH ST, AMERICUS 31709
DUDNEY, WILLIAM C. 36 ACT P
1017 NORTH HOUSTON RD, WARNER ROBINS 31093
DUFFELL, G. MICHAEL 29 ACT IM
1365 CLIFTON RD NE, ATLANTA 30322
DUGGAN, ASA D. 54 ACT FP
RTE 2 BOX 162-K, WASHINGTON 30673
DUGGAN, C.A., JR. 06 ACT R
380 HOSPITAL DR, MACON 31201
DUHDN, FRED J. 70 ACT FP
PO BOX 1066, LAFAYETTE 30728
DUKE, GRADY F. 59 ACT GS
205 GRAEFE ST, GRIFFIN 30223
DUKE, JDHN F., III 36 ACT FP
PO BOX 1088, FORT VALLEY 31030

DUKE, PEGGY G. 29 ACT AN
35 LINDEN AVE NE, ATLANTA 30365
DULL, MARTHA KATHERINE 22 ACT OBG
2831 NORTHLAKE PKY STE 102, TUCKER 30084
DULOCK, MALCOLM P. 29 ACT FP
6185 SOUTH BUFORD HWY, NORCROSS 30071
DUNAGAN, H. JDSEPHINE RDSE 13 ACT PD
2121 FOUNTAIN DR STE 200, SNELLVILLE 30278
DUNAWAY, JAMES B. 59 ACT PD
666 SOUTH EIGHTH ST, GRIFFIN 30223
DUNAWAY, MARSHALL C. 65 ACT IM
808 GORDON AVE, THOMASVILLE 31792
DUNBAR, ERNEST A., JR. 16 ACT PD
1035 MAIN ST, FOREST PARK 30050
DUNBAR, MARK R. 29 I&R OPH
2031 INNWOOD RD NE, ATLANTA 30329
DUNBAR, RDNALD W. 29 ACT AN
20 LINDEN AVE NE STE 725, ATLANTA 30368
DUNBAR, WALTER S. 29 ACT IM
384 PEACHTREE ST NE, ATLANTA 30308
DUNCAN, J. HARRY 11 ACT OPH
115 MCLAWS, SAVANNAH 31405
DUNCAN, ROY G. 17 ACT PD
74 MEDICAL SQUARE, MARIETTA 30060
DUNKELBERGER, J.A. 30 R OTO
139 BELLE POINT PKY, BRUNSWICK 31520
DUNLAP, DICKSDN B. 54 ACT IM
VA HOSPITAL, AUGUSTA 30904
DUNLAP, ERNEST B., JR. 45 R ORS
12 EAST THIRD ST, MANCHESTER 31816
DUNN, BYRDN H. 48 ACT OBG
1359 MILSTEAD RD STE 103, CONYERS 30207
DUNN, JAMES R., JR. 36 S GS
ROBINS AFB, WARNER ROBINS 31098
DUNN, LAURENCE B. 11 ACT GP
PO BOX 205, BLUFFTON SC 29910
DUNN, MAURICE 54 ACT P
3012 PARK AVE, AUGUSTA 30909
DUNN, WILLIAM R. 13 ACT PD
PO BOX 669, CUMMING 30130
DUNSTAN, EDGAR M. 29 ACT IM
710 PINETREE DR, DECATUR 30030
DUPDNT, LDUIS 47 ACT GS
PO BOX 7000, COLUMBUS 31995
DUPREE, J.T. 42 S GS
VA CENTER, DUBLIN 31021
DUPREE, THDMAS E. 06 ACT FP
577 WALNUT ST, MACON 31201
DUQUE-DIZDN, GRACE T. 06 ACT AN
777 HEMLOCK ST, MACON 31208
DURALDE, FERNANDD U. 29 ACT GS
2760 FELTON DR, EAST POINT 30344
DURDEN, JOHN G., JR. 47 ACT GS
1915 SEVENTH AVE, COLUMBUS 31901
DURDEN, MARK D., III 06 ACT FP
1095 GRAY HWY, MACON 31201
DURISCH, LAWRENCE L. 34 ACT OTO
304 ENOTA DR, GAINESVILLE 30505
DURRANI, FAUZIA K. 56 ACT PD
107 WOODROW WILSON DR, VALDOSTA 31602
DURRENCE, LEDNARD C., JR. 72 ACT FP
PO BOX 231, BLACKSHEAR 31516
DURRETT, DDNALD M. 29 ACT DR
1170 CLEVELAND AVE, EAST POINT 30344
DUTT, CYRIL P. 16 ACT GS
6507 PROFESSIONAL PL, RIVERDALE 30274
DUTTERA, M. JULIAN, JR. 68 ACT ON
303 SMITH ST, LA GRANGE 30240
DUVALL, DAVID W. 26 ACT IM
PO BOX 1194, CORDELE 31015
DYCKMAN, EDWARD 29 ACT IM
5669 PEACHTREE-DUNWOODY RD, ATLANTA 30342
DYER, WALLACE K., II 29 I&R OTO
2676 WHISPERING PINES CT, DECATUR 30033
DYKEN, PAUL R. 54 ACT PD
MEDICAL COLLEGE OF GEORGIA, AUGUSTA 30912

DYNIN, MICHAELA 11 ACT P
6606 ABERCORN ST, SAVANNAH 31405

E

EARLEY, WILLIAM H. 22 ACT P
1935 CLIFF VALLEY WAY ' 110, ATLANTA 30329
EASLEY, CONRAD H. 76 ACT ORS
1103 MEMORIAL DR, DALTON 30720
EASLEY, CURRAN S., JR. 68 ACT PD
606 SOUTH GREENWOOD ST, LA GRANGE 30240
EASLEY, PAUL E. 34 ACT AN
PO BOX 2979, GAINESVILLE 30503
EASON, HARMER O., JR. 79 ACT IM
501 WESTBERRY ST, SYLVESTER 31791
EATON, JAMES M., JR. 20 ACT U
103 WOODBINE CIR, NEWNAN 30263
EATON, S. BOYO 29 ACT DR
3200 HOWELL MILL RD NW, ATLANTA 30327
EAVES, ROBERT F., JR. 22 ACT FP
2390 MAIN ST, TUCKER 30084
EBERHARDT, REESE C. 06 ACT FP
227 ORANGE ST, MACON 31201
ECHEMENDIA, MARIANO M. 29 ACT OBG
384 PEACHTREE ST NE, ATLANTA 30308
ECHOLS, GEORGE L., JR. 54 ACT PD
1021 15TH ST, AUGUSTA 30901
ECHOLS, JOSEPH M. 54 ACT OBG
1430 HARPER ST, AUGUSTA 30910
EDDINGS, TALLY H., II 72 ACT
228 RIVERSIDE DR, WAYCROSS 31501
EDELSON, STEPHEN B. 22 ACT FP
5536-A FLAT SHOALS RD, DECATUR 30034
EDEN, SAMUEL W. 13 ACT IM
1029 WINDING RIDGE CT, DUNWOODY 30338
EOENFIELO, R.W., MO FACS 06 ACT GS
726 FIRST ST, MACON 31201
EDGENS, JACK R. 27 ACT R
RTE 10, ROME 30161
EDMONDSON, H.T., JR. 54 ACT GS
VA HOSPITAL, AUGUSTA 30904
EDMONOSON, MICHAEL L. 66 ACT OBG
2205 MADISON AVE, TIFTON 31794
EOMONDSON, STEPHEN W. 29 ACT P
4555 NORTH SHALLOWFORD RD, ATLANTA 30338
EDMONDSON, T.L. 66 ACT FP
PO BOX 827, TIFTON 31794
EDWARDS, A. JOSEPH, JR. 11 ACT OBG
PO BOX 23498, SAVANNAH 31499
EOWARDS, ERNEST G., JR. 11 ACT ORS
44 MEDICAL ARTS CENTER, SAVANNAH 31405
EDWARDS, M. OELMAR 47 ACT GS
804 FOURTH AVE, COLUMBUS 31901
EOWARDS, PHILLIP O. 13 ACT U
2121 FOUNTAIN DR STE D, SNELLVILLE 30278
EDWARDS, WALTER C. 29 ACT ORS
1938 PEACHTREE RD NW, ATLANTA 30309
EHIK, JULIUS 29 ACT P
3985 SOUTH COBB DR STE 120, SMYRNA 30080
EHRLICH, M.A. 21 ACT PD
231 EAST BROUGHTON ST, BAINBRIDGE 31717
EIOEX, MARSHALL F. 22 ACT IM
487 WINN WAY STE 202, DECATUR 30030
EIDEX, MAXWELL A. 22 ACT IM
487 WINN WAY STE 202, DECATUR 30030
EIDSON, RODGER H. 76 ACT OBG
1109 BURLEYSON DR STE A, DALTON 30720
EISENBAND, ROBERT M. 29 ACT GE,IM
4555 NORTH SHALLOWFORD RD, ATLANTA 30338
EITH, RONALD E. 34 ACT A
1235 SPRING ST NE, GAINESVILLE 30501
EKELEDO, BROWN N. 06 ACT GS
770 PINE ST STE 160, MACON 31201
EL GAMMAL, T.A. 54 ACT R
MEDICAL COLLEGE OF GEORGIA, AUGUSTA 30912
ELDER, JOHN F. 15 ACT OBG
740 PRINCE AVE, ATHENS 30601
ELDRIDGE, F.G. 56 ACT R
2307 RIVERHILL DR, VALDOSTA 31602
ELGUINDI, AHMED S. 54 ACT PUD
VA HOSPITAL, AUGUSTA 30910
ELLINGTON, PRESTON D. 54 ACT PD
824 WINDSOR CT, AUGUSTA 30904
ELLIOTT, C.B. 27 ACT GS
134 EAST FAIRMOUNT AVE, CEDARTOWN 30125
ELLIOTT, OEAN COOK 54 ACT OTO
3569 CARNOUSTIE DR, MARTINEZ 30907
ELLIOTT, J.L. 11 ACT IM
212 EAST HUNTINGDON ST, SAVANNAH 31401
ELLIOTT, PAUL M. 75 ACT FP
PO BOX 937, JESUP 31545
ELLIOTT, RALPH A. 29 R IM
1968 LAVISTA CIR, TUCKER 30084
ELLIS, JOHN O. 29 ACT R
1938 PEACHTREE RD NW STE 111, ATLANTA 30308
ELLIS, RALPH GRIER, JR. 30 ACT AN
100 DARIEN HWY, BRUNSWICK 31520
ELLISON, HOWARO S. 48 ACT IM
1359 MILSTEAD RD, CONYERS 30207
ELLISON, LOIS T. 54 ACT PUD
1120-15TH ST, AUGUSTA 30912
ELLISON, ROBERT G. 54 ACT TS
MEDICAL COLLEGE OF GEORGIA, AUGUSTA 30912
ELLZEY, B. FRANK 22 ACT OBG
1462 MONTREAL RD STE 107, TUCKER 30084
ELLZEY, JANE L. 22 ACT PD
5040 SNAPFINGER WOODS DR, DECATUR 30035
ELMER, R.A. 29 ACT R
6500 VERNON WOODS DR NE, ATLANTA 30328
ELROD, BRUCE A. 70 ACT PTH
PO BOX 2068, FT OGLETHORPE 30742
ELROD, DAN B. 01 ACT FP
PROFESSIONAL ARTS CENTER, HAZLEHURST 31539
ELSAHY, NABIL IBRAHIM 16 ACT PS
6524 PROFESSIONAL PL, RIVERDALE 30274
ELSAS, LOUIS J., II 29 A OS
PO DRAWER AM, ATLANTA 30322
ELSEA, WILLIAM R. 29 A PH
99 BUTLER ST SE, ATLANTA 30303
ELSNER, WILLIAM 29 ACT N
237 MEDICAL WAY, RIVERDALE 30274
ELSON, EILEEN F. 29 R FP
12 HOWELL MILL PLANTATION NW, ATLANTA 30327
ELY, RALPH L. 65 ACT GS
114 MIMOSA DR, THOMASVILLE 31792
ENCINAS, SENEN J. 06 ACT FP
90 CULLODEN RD, FORSYTH 31029
ENGEL, JOEL S. 29 ACT OBG
7175 DUNHILL TERR NW, ATLANTA 30328
ENGEL, NANCY L. 29 ACT P
2905 PEACHTREE RD NE, ATLANTA 30363
ENGELHARDT, SAMUEL M., III 29 ACT OBG
993 JOHNSON FERRY RD, NE, ATLANTA 30342
ENGLER, HAROLD S. 54 ACT GS
1503 WINTER ST, AUGUSTA 30904
ENGLISH, INMAN C. 36 ACT PD
116 SOUTH HOUSTON RD, WARNER ROBINS 31093
ENSLEN, PHILLIP J. 71 ACT FP
BOX 866, MONROE 30655
EPPLE, WALTER D. 54 ACT N
DOCTORS HOSP MED PLAZA ' 310, AUGUSTA 30909
EPSTEIN, JACOB 29 ACT OBG
1175 PEACHTREE ST NE, ATLANTA 30309
ERHARDT, WALTER L., JR. 23 ACT PS
507 THIRD AVE, ALBANY 31701
ERICKSON, DOUGLAS J. 06 ACT PTH
MEDICAL CENTER OF CENTRAL GA, MACON 31208
ERICKSON, WILLIAM G. 22 ACT GP
1745 OLD SPRINGHOUSE LN, DUNWOODY 30338
ERICSSON, JUOITH A. 29 ACT AN
20 LINDEN AVE NE STE 419, ATLANTA 30365
ERMUTLU, ILHAN M. 29 A P
4288 GLENGARY DR NE, ATLANTA 30342
ERWIN, GOODLOE Y. 15 ACT IM
1010 PRINCE AVE, ATHENS 30601
ESCALERA, GUSTAVO A. 38 ACT GS
STE 9 HENRY PROF BLDG, STOCKBRIDGE 30281
ESCONDO, GERSON Z. 47 ACT P
STE 200 DOCTORS BLDG, COLUMBUS 31901
ESENER, ISMAIL 31 ACT OBG
PO BOX 1238, CALHOUN 30701
ESPINOZA, FRANK T. 29 ACT GS
3065 AUSTELL RD, MARIETTA 30060
ESPY, GOODMAN B., III 17 ACT OBG
72 PLAZA WAY, MARIETTA 30060
ESPY, PAUL D. 17 ACT D
114 CHERRY ST STE E, MARIETTA 30090
ESTES, BEN N. 54 ACT NS
820 SEBASTIAN WAY 4-C, AUGUSTA 30910
ESTES, EDWARD E., JR. 34 ACT U
1114 VINE ST, GAINESVILLE 30505
ESTES, J.W. 29 ACT CDS
993 JOHNSON FERRY RD, ATLANTA 30342
ESTES, RICHARD C. 29 ACT U
35 COLLIER RD NW, ATLANTA 30309
ESTES, THOMAS L. 19 ACT GS
3004 SECOND ST SE, MOULTRIE 31768
ESTRADA, MARCELLO A. 68 ACT N
303 MEDICAL DR STE 406, LA GRANGE 30240
ETCHASON, GREGORY J. 36 ACT IM
PO BOX 1435, FORT VALLEY 31030
ETHERIDGE, JOHN G. 06 ACT PTH
BOX 6000, MACON 31208
EUBANKS, A. BENJAMIN 29 ACT P
1970 CLIFF VALLEY WAY NE, ATLANTA 30329
EUBANKS, WILLIAM L. 29 ACT OPH
490 PEACHTREE ST NE, ATLANTA 30308
EVANS, ALBERT L. 29 ACT GS
735 PIEDMONT AVE NE, ATLANTA 30308
EVANS, ARTHUR R. 16 ACT GP
3681 AUDITORIUM WAY, COLLEGE PARK 30337
EVANS, CASSANDRA B. 14 ACT EM
2301 WALESKA RD, CANTON 30114
EVANS, E.C. 29 ACT IM
340 BOULEVARD NE, ATLANTA 30312
EVANS, ELLIS W. 06 ACT GS
770 PINE ST STE 220, MACON 31201
EVANS, GEORGE H. 42 ACT U
ERIN PARK, DUBLIN 31021
EVANS, JAMES A. 47 ACT AN
PO BOX 2748, COLUMBUS 31902
EVANS, JAMES P. 11 ACT PD
5102 PAULSEN ST #3, SAVANNAH 31405
EVANS, JOHN S. 29 ACT GS
735 PIEDMONT AVE NE, ATLANTA 30308
EVANS, RAYMOND C. 66 ACT R
PO BOX 388, TIFTON 31793
EVERETT, THEODORE 54 ACT U
820 ST SEBASTIAN WAY, AUGUSTA 30902
EVERIDGE, GEORGE J. 47 ACT OBG
MEDICAL ARTS BLDG, COLUMBUS 31901
EVERSOLE, JOSEPH W. 06 ACT PTH
7320 ZEBULON RD, MACON 31210
EWING, DOUGLAS E. 54 ACT P
2350 WASHINGTON RD, AUGUSTA 30904
EWING, R.B. 06 ACT D
380 HOSPITAL DR, MACON 31201
EZEKWUECHE, CHRISTIAN M. 06 ACT OBG
770 PINE ST STE 310, MACON 31201
EZZARD, GEORGE P. 13 ACT FP
105 CROGAN ST, LAWRENCEVILLE 30245

F

FACKLER, CARL D. 29 ACT ORS
105 COLLIER RD NW STE 5000, ATLANTA 30309

FACKLER, WILLIAM B., JR. 68 ACT IM
303 SMITH ST, LA GRANGE 30240
FADEL, HOSSAM E. 54 ACT OBG
MEDICAL COLLEGE OF GEORGIA, AUGUSTA 30912
FADEL, SKINA H. 54 ACT AN
3503 LOST TREE CT, AUGUSTA 30907
FAGIN, RONALD R. 11 ACT IM
835 EAST 65TH ST, SAVANNAH 31405
FAJMAN, WILLIAM A. 29 ACT R
EMORY UNIVERSITY, ATLANTA 30322
FALBAUM, HARTLEY L. 65 ACT ORS
PO BOX 1957, THOMASVILLE 31792
FALLS, DDRTH G. 54 I&R PTH
MEDICAL COLLEGE OF GEORGIA, AUGUSTA 30912
FANG, KUO-KANG 23 ACT IM
507 THIRD AVE STE 3, ALBANY 31701
FANTZ, JON SCDTT 48 ACT IM,GE
1315 MILSTEAD RD, CONYERS 30207
FARIA, MIGUEL A., JR. 06 ACT NS
3 BACONSFIELD PK STE 80, MACON 31211
FARKAS, STEPHEN J. 34 ACT OPH
664 LANIER PARK DR NE, GAINESVILLE 30501
FARMER, CHARLES W., JR. 20 ACT OTO
PO BOX 160, NEWNAN 30263
FARR, WILLIAM L., JR. 54 ACT IM
820 ST SEBASTIAN WAY, AUGUSTA 30902
FARRELL, ROBERT A. 27 ACT PTH
FLOYD COUNTY HOSPITAL, ROME 30161
FARROW, ROYAL T. 76 ACT PD
1109 BURLEYSON DR, DALTON 30720
FAUCHER, MARIE 48 ACT AN
3306 HIDDEN FOREST DR, SNELLVILLE 30278
FAULK, CARL F. 17 ACT AN
PO BOX 7449, MARIETTA 30065
FAULKNER, ALVA H. 54 ACT OBG
1505 WINTER ST, AUGUSTA 30904
FAULKNER, ROBERT L. 48 ACT FP
4186 MILL ST, COVINGTON 30209
FEINERMAN, LOIS K. 17 ACT D
1975 NORTH PARK PL STE 100, ATLANTA 30339
FEINERMAN, MICHAEL B. 17 ACT PS
1975 NORTH PARK PL STE 100, ATLANTA 30339
FEINGOLD, ALAN O. 22 ACT IM
755 COLUMBIA DR STE 618, DECATUR 30030
FEINSMITH, LESLIE M. 16 ACT NEP
150 MEDICAL WAY STE A, RIVERDALE 30274
FEINSTEIN, ARTHUR C. 29 ACT GS,ON
478 PEACHTREE ST NE, ATLANTA 30308
FELDER, LOUIS H. 29 ACT IM
35 COLLIER RD NW, ATLANTA 30309
FELDER, RICHARD E. 29 ACT P
6363 ROSWELL RD NE, ATLANTA 30328
FELDMAN, DANIEL M. 56 ACT PD
2000 NORTH PATTERSON ST, VALDOSTA 31602
FELDMAN, DANIEL S. 54 ACT N
1120 15TH ST, AUGUSTA 30912
FELDMAN, ELAINE B. 54 ACT IM
MEDICAL COLLEGE OF GEORGIA, AUGUSTA 30912
FELDMAN, JACK A. 54 ACT GS,ON
1021 - 15TH ST STE 12, AUGUSTA 30901
FELICIANO, E.A. 29 ACT IM
490 PEACHTREE ST NE, ATLANTA 30308
FELKER, FDRT F., JR. 76 ACT FP
216 NORTH PENTZ ST, DALTON 30720
FELLNER, DONALD W. 22 ACT ORS
487 WINN WAY STE 101, DECATUR 30030
FELONG, MICHAEL F. 30 ACT IM
2922 LA COSTA AVE, CARLSBAD CA 92008
FERGUSON, DANIEL S. 29 ACT IM
35 COLLIER RD NW STE 200, ATLANTA 30309
FERGUSDN, FREDERICK CAMPBELL 54 ACT U
3623 J DEWEY GRAY CIR ' 313, AUGUSTA 30909
FERGUSON, IRA A., JR. 29 ACT GS
EMORY UNIVERSITY CLINIC, ATLANTA 30322
FERGUSON, JAMES P. 27 ACT NS
1825 MARTHA BERRY BLVD, ROME 30161

FERGUSDN, RDBERT C. 34 ACT CD,IM
710 BROAD ST SE, GAINESVILLE 30501
FERGUSON, WILSON J. 29 R GS
2000 SIX BRANCHES DR, ROSWELL 30076
FERN, DAVID R. 22 ACT GS
500 IRVIN CT STE C-210, DECATUR 30030
FERNANDEZ, ANDRES R. 16 ACT FP
195 UPPER RIVERDALE RD, RIVERDALE 30274
FERNANDEZ, ANTONIO 06 ACT ORS
167 RIVERSIDE DR, MACON 31201
FERNANDEZ, B.P. 42 ACT IM
8473 BRIARWOOD RD, JACKSONVILLE FL 32217
FERNANDEZ, E.J. 07 ACT FP
PO BOX 587, ELLIJAY 30540
FERNANDEZ, JDSE M. 17 ACT PD
2550 WINDY HILL RD STE 109, MARIETTA 30067
FERRARI, DURVAL A. 17 ACT DR
3949 SOUTH COBB DR, SMYRNA 30080
FERRELL, M. LYNN 49 ACT FP
325 EAST BROAD ST, SPARTA 31087
FERRELL, T.J., JR. 72 ACT IM
1921 ALICE ST, WAYCROSS 31501
FERRELL, WILLIAM C. 34 ACT R
745 SPRING ST, GAINESVILLE 30505
FERRIER, FRANK L. 29 ACT TS
3250 HOWELL MILL RD STE 303, ATLANTA 30327
FERRIS, HAROLD A. 29 ACT IM
478 PEACHTREE ST NE, ATLANTA 30308
FIANDACA, MASSIMO S. 29 I&R NS
1073 DE LEON DR, CLARKSTON 30021
FIEDOTIN, ARNOLDO 29 ACT IM
5665 PEACHTREE DUNWOODY RD, ATLANTA 30342
FIELDER, DENNIS L. 29 ACT AN
1000 JOHNSON FERRY RD, ATLANTA 30342
FIGUEREDO, JORGE V. 32 ACT GS
1001 THORNTON RD #414, LITHIA SPRINGS 30057
FILARDI, GERALD A. 22 ACT U
755 COLUMBIA DR STE B, DECATUR 30030
FILIP, DONALD J. 29 ACT ON
105 COLLIER RD NW, ATLANTA 30309
FILLINGIM, DAVID B. 11 ACT FP
449 ABERCORN ST, SAVANNAH 31401
FILLINGIM, DAVID W. 11 ACT OBG
5354 REYNOLDS ST STE 422, SAVANNAH 31405
FILLINGIM, JOHN M. 11 ACT FP
449 ABERCORN ST, SAVANNAH 31401
FILSDN, EDGAR J. 11 ACT R
9 MEDICAL ARTS CENTER, SAVANNAH 31405
FILSTEIN, ALLEN B. 48 ACT D
1359 MILSTEAD RD, CONYERS 30207
FINCH, CHARLES S., JR. 17 ACT AN
3201 RIDGEWOOD RD NW, ATLANTA 30327
FINCH, HENRY M. 29 R CRS

FINCH, STUART M. 54 ACT P
MEDICAL COLLEGE OF GEORGIA, AUGUSTA 30912
FINE, ROBERT M. 22 ACT D,DMP
487 WINN WAY STE 209, DECATUR 30030
FINEBERG, EDWARD M. 54 ACT OPH
2100 CENTRAL AVE, AUGUSTA 30904
FINEGAN, ROBERT F. 29 ACT AN
2760-B FELTON DR, EAST POINT 30344
FINEMAN, STANLEY M. 17 ACT A
833 CAMPBELL HILL ST ' 490, MARIETTA 30090
FINGER, ELLIOTT R. 11 ACT PS
11706 MERCY BLVD, SAVANNAH 31406
FINKELMAN, DAVID 17 ACT IM,GE
1001 THORNTON RD, L02, LITHIA SPRINGS 30057
FINLAYSDN, DDNALD C. 29 ACT AN
1365 CLIFTON RD, ATLANTA 30322
FINNERTY, DDNALD P. 29 ACT U
PO BOX 26104, ATLANTA 30335
FINNEY, C.E. 23 R OPH
RT 4 BOX 73, LEESBURG 31763
FINNEY, H. RAY 54 ACT U
1512 ANTHONY RD, AUGUSTA 30904

FINUCANE, BRENDAN 29 ACT AN
69 BUTLER ST SE, ATLANTA 30303
FISHBEIN, SUMNER 54 ACT OPH
820 ST SEBASTIAN STE 5-F, AUGUSTA 30902
FISHER, GEORGE B. 68 ACT FP
MAPLE ST, FRANKLIN 30217
FISHER, GILBERT F., JR. 17 ACT OBG
41 MARGARET AVE, MARIETTA 30060
FISHER, J. EDWARD 29 ACT OBG
340 BOULEVARD NE, ATLANTA 30312
FISHER, JOHN F. 54 ACT
MEDICAL COLLEGE OF GEORGIA, AUGUSTA 30912
FISHER, WILLIAM R. 29 ACT OTO
490 PEACHTREE ST STE 265-C, ATLANTA 30308
FITE, J. DONALD 22 ACT OPH
PO BOX 1798, DECATUR 30030
FITZGERALD, EDMUND M., JR. 42 S IM
VA CENTER, DUBLIN 31021
FITZHUGH, F.W., JR. 29 ACT IM
1938 PEACHTREE RD NW, ATLANTA 30309
FITZPATRICK, PAUL E. 29 ACT IM
6185 JONESBORO RD, MORROW 30260
FIVEASH, ARLIE E. 54 ACT R
820 ST SEBASTIAN STE 1-A, AUGUSTA 30902
FIX, RICHARD M. 30 ACT PD
2705 WILDWOOD DR, BRUNSWICK 31520
FLANAGAN, WILLIAM C., JR. 47 ACT OBG
500 18TH ST STE B-10, COLUMBUS 31901
FLANAGIN, W. STEWART 54 ACT PS
1125 DRUID PARK AVE, AUGUSTA 30904
FLANDERS, HUGH D. 11 ACT GS
22 MEDICAL ARTS CENTER, SAVANNAH 31405
FLECK, RALPH E., JR. 10 ACT ORS
148 CLINIC AVENUE, CARROLLTON 30117
FLEMING, ANN W. 68 ACT PD
1001 THORNTON RD, 203, LITHIA SPRINGS 30057
FLEMING, CURTIS 47 ACT OBG
STE 102 DOCTORS BLDG, COLUMBUS 31901
FLEMING, LAMAR L. 29 ACT ORS
1365 CLIFTON RD NE, ATLANTA 30322
FLEMING, MICHAEL T. 17 ACT NS
1680 MULKEY RD STE B, AUSTELL 30001
FLEMING, SIDNEY H. 22 ACT P
2238 HILL PARK CT, DECATUR 30033
FLESCH, W.L. 72 R U
RTE 2 BOX 57, TOWNSEND 31331
FLETCHER, GERALD F. 29 ACT IM
300 BOULEVARD NE, ATLANTA 30312
FLETCHER, MELVIN R. 17 ACT PD
833 CAMPBELL HILL #360, MARIETTA 30090
FLINCHUM, DARIUS 29 ACT ORS
340 BOULEVARD NE STE 540, ATLANTA 30312
FLINT, L. AUSTIN 14 ACT R
110 WALESKA RD, CANTON 30114
FLORENCE, THDMAS J. 29 ACT U
2550 WINDY HILL RD, MARIETTA 30062
FLDURNDY, EDWIN E., JR. 23 ACT FP
810-13TH AVE, ALBANY 31701
FLDURNDY, HENRY W. 30 ACT OBG
2444 PARKWOOD DR, BRUNSWICK 31520
FLOWERS, EUGENE MONROE 66 ACT FP
PO BOX 86, TIFTON 31794
FLOWERS, THOMAS EDWARD 27 ACT OPH
103 JOHN MADDOX DR, ROME 30161
FLOYD, JOSEPH B. 13 ACT AN
2121-B FOUNTAIN DR, SNELLVILLE 30278
FLDYD, T.J., JR. 59 R GS
543 BROOK CIR, GRIFFIN 30223
FLDYD, WALDD E., JR. 06 ACT ORS,HS
870 HIGH ST, MACON 31201
FLYNN, JAMES T., JR. 19 ACT OTO
PO BOX 1530, MOULTRIE 31768
FLYTHE, CARDL W. 29 ACT AN
80 BUTLER ST, ATLANTA 30303
FODOR, FRANK 06 ACT P
770 PINE ST STE L-30, MACON 31201

FOEGE, WILLIAM H. 29 S
1600 CLIFTON RD NE, ATLANTA 30333
FOKES, ERNEST C. 22 ACT NS
370 WINN WAY #201, DECATUR 30030
FOKES, ROBERT E., JR. 19 ACT OPH
PO BOX 1139, MOULTRIE 31768
FORD, HENRY J. 15 ACT P
1010 PRINCE AVE, ATHENS 30601
FOREHAND, RONALD L. 15 S GP
460 COLLIERS CREEK RO, WATKINSVILLE 30677
FORESTER, B.W. 06 ACT IM
618 ORANGE ST, MACON 31201
FORESTNER, JOHN E. 29 ACT AN
HENRIETTA EGLESTON HOSP, ATLANTA 30322
FORMBY, LARRY H. 27 ACT U
1013 NORTH FIFTH AVE, ROME 30161
FORREST, JOHN W. 34 ACT OPH
1128 VINE ST, GAINESVILLE 30505
FORRESTER, EDWARD S., JR. 66 ACT ORS
1610 JOHN ORR DR, TIFTON 31794
FORSHNER, JOHN G. 76 ACT D
1206 WEST WAUGH, OALTON 30720
FORSYTH, OOUGLAS H. 29 ACT IM
993 JOHNSON FERRY RD NE, ATLANTA 30342
FORTSON, LUTHER G., JR. 17 ACT IM
108 MARGARET AVE, MARIETTA 30060
FORTSON, MARK R. 47 ACT IM
1005 TALBOTTON RO, COLUMBUS 31995
FOSTER, CATHERINE E. 71 ACT OBG
924 WEST SPRING ST, MONROE 30655
FOSTER, GILBERT J., JR. 29 ACT U
490 PEACHTREE ST STE 578-C, ATLANTA 30308
FOSTER, GUROON R., JR. 38 ACT FP
55 SIMS ST, MCOONOUGH 30253
FOSTER, H.R. 22 ACT PO,PDC
7660 COVINGTON HWY, LITHONIA 30058
FOSTER, HENRY A. 59 ACT FP
319 SOUTH NINTH ST, GRIFFIN 30223
FOSTER, THOMAS V. 47 ACT P
1953 SEVENTH AVE, COLUMBUS 31904
FOUNTAIN, ARTHUR J., JR. 47 ACT N
2119 WARM SPRINGS RD, COLUMBUS 31904
FOUNTAIN, JOEL R. 06 ACT FP
100 CULLOOEN RO, FORSYTH 31029
FOUNTAIN, JOHN A. 48 ACT D
1349 MILSTEAO RO, CONYERS 30207
FOUNTAIN, LINDA M. 47 ACT PD
2725 EDGEWOOD RD, COLUMBUS 31906
FOUNTAIN, T. GRAY 23 ACT GS
910 NORTH JEFFERSON, ALBANY 31708
FOWLER, C. DIXON 29 ACT PO
27 EIGHTH ST NE, ATLANTA 30309
FOWLER, JOHN E., MD FAAFP 60 ACT FP
PO BOX 825, CLAYTON 30525
FOWLER, MAJOR F. 29 ACT U
2949 CARRIAGE DR, S OAYTONA FL 32019
FOWLER, MARK W. 23 ACT FP
1010 NORTH MADISON ST, ALBANY 31701
FOWLER, R.W., JR. 17 ACT PD
680 CHURCH ST, MARIETTA 30060
FOX, BRENT 47 ACT OTO
2831 CROMWELL OR, COLUMBUS 31906
FRADKIN, MAURY L. 29 ACT OBG
5675 PEACHTREE-DUNWOODY RO, ATLANTA 30342
FRADY, ROBERT P. 76 ACT OTO
5161 PUTNAM RO, COHUTTA 30710
FRANCH, ROBERT H. 29 ACT IM
1365 CLIFTON RD NE, ATLANTA 30322
FRANCO, NED M. 29 ACT U
960 JOHNSON FERRY RD NE, ATLANTA 30342
FRANCO, RAMON S. 29 ACT OTO
993-D JOHNSON FERRY RD, ATLANTA 30342
FRANCO, RICHARD D. 29 ACT N
993-F JOHNSON FERRY RD NE, ATLANTA 30342
FRANK, MARTIN J. 54 ACT IM
MEOICAL COLLEGE OF GEORGIA, AUGUSTA 30912
FRANK, MILTON, III 29 ACT CD,IM
1372 PEACHTREE ST NE STE 301, ATLANTA 30309
FRANKLIN, ERNEST W. 29 ACT GYN
5669 PEACHTREE-DUNWOODY RD, ATLANTA 30342
FRANKLIN, REGINALD K. 29 A IM
384 PEACHTREE ST STE 1101, ATLANTA 30308
FRASER, WHITMAN 62 ACT FP
PO BOX 406, HINESVILLE 31313
FRAZIER, WESLEY T. 29 ACT AN
EMORY UNIVERSITY HOSPITAL, ATLANTA 30322
FREANT, LAWRENCE J. 06 ACT CD
856 FIRST ST, MACON 31201
FREDERICKSON, EVAN L. 29 ACT AN
EMORY UNIVERSITY, ATLANTA 30322
FREEDMAN, ALAN I. 29 ACT AN
35 COLLIER RD NW STE 560, ATLANTA 30309
FREEDMAN, L.M. 11 ACT GS
7704 HUNTERS GROVE, JACKSONVILLE FL 32216
FREEDMAN, MILTON H. 29 ACT IM
340 BOULEVARO NE, ATLANTA 30312
FREEDMAN, MURRAY A. 54 ACT OBG
820 ST SEBASTIAN STE 63, AUGUSTA 30902
FREEDMAN, SANDRA N. 54 ACT R
#7 RETREAT RD, AUGUSTA 30909
FREEMAN, ATWOOD M., JR. 23 ACT ORS
1105 PALMYRA RD, ALBANY 31708
FREEMAN, CHARLES 54 ACT ORS
820 ST SEBASTIAN WAY STE 8, AUGUSTA 30902
FREEMAN, JAMES C. 55 ACT FP
106 EAST TELEPHONE ST, SYLVANIA 30467
FREEMAN, JAMES M. 23 ACT CDS
500 THIRD AVE, ALBANY 31701
FREEMAN, LAWRENCE L. 22 ACT FP
3652 CHAMBLEE-OUNWOOOY RD, CHAMBLEE 30341
FREEMAN, MALCOLM G. 29 ACT OBG
69 BUTLER ST SE, ATLANTA 30303
FREEMAN, RONALD A. 06 ACT PS
380 HOSPITAL DR, MACON 31201
FREEMAN, THOMAS R. 11 ACT GS
200 EAST 31ST ST, SAVANNAH 31401
FREEMAN, WILLIAM T. 30 ACT AN
PO BOX 1354, BRUNSWICK 31521
FREGOSI, ALBERT H. 22 ACT U
2977 WILSONS CROSSING CT 'B, DECATUR 30033
FREID, NORMAN O. 13 ACT OBG
2200 FOUNTAIN OR, SNELLVILLE 30278
FREIREICH, RONALD 16 ACT CO
29 SW UPPER RIVERDALE RD, RIVERDALE 30274
FRENCH, JAMES B. 34 ACT OBG
660-E LANIER PARK OR NE, GAINESVILLE 30505
FRESH, JAMES W. 08 ACT GP,PTH
PO BOX 10, SARDIS 30456
FREYRE, ROBERT C. 48 ACT FP
943 COURT ST, CONYERS 30207
FRIED, OENNIS A. 22 ACT CRS
558 MEDLOCK RO, OECATUR 30030
FRIEDEWALD, WILLIAM F. 29 R IM
28 VERNON GLENN CT, ATLANTA 30338
FRIEDMAN, MARK F. 30 ACT P,CHP
2927 DEMERE RD, ST SIMONS IS 31522
FRIEDRICH, ERIC W. 30 ACT OTO
3216 SHRINE RD, BRUNSWICK 31520
FRIST, STEPHEN 16 ACT PTH
11 SW UPPER RIVEROALE RO, RIVEROALE 30274
FROLICH, DAVIO J. 06 ACT R
PO BOX 6000, MACON 31208
FROMM, STEFAN H. 76 ACT GS
PO BOX 1969, OALTON 30720
FROST, H.R. 25 R FP
EAST PINE ST, SWAINSBORO 30401
FUERST, JULIAN F. 22 ACT OBG
755 COLUMBIA DR STE 702, DECATUR 30030
FULENWIDER, J. TIMOTHY 29 ACT GS
1365 CLIFTON RD, ATLANTA 30322
FULGHUM, C.B., JR. 29 ACT P
1970 CLIFF VALLEY WAY NE, ATLANTA 30329
FULMER, THOMAS E. 29 ACT P
1711 UPPER GATE DR NE, ATLANTA 30307
FUNK, F. JAMES, JR. 29 ACT ORS
105 COLLIER RD NW, ATLANTA 30309
FUNK, MARK R. 47 ACT IM
909 CENTER ST, COLUMBUS 31901
FUNK, SIDNEY A. 29 ACT OBG
5675 PEACHTREE-DUNWOOOY RO, ATLANTA 30342
FUSSELL, DANIEL O. 36 ACT IM
1540 WATSON BLVO, WARNER ROBINS 31093
FUTCH, C.B. 30 ACT GS
2432 PARKWOOO OR, BRUNSWICK 31520
FUTCH, WILLIAM A. 48 ACT FP
PO BOX 460, CONYERS 30207

G

GABLE, THOMAS W. 29 ACT P
3400 PEACHTREE RO NE, ATLANTA 30326
GABLER, REGINA 29 ACT OBG
20 LINOEN AVE NE, ATLANTA 30365
GAFFORD, A.V. 27 R OPH
101 MAPLEWOOO DR, ROME 30161
GAINER, JAMES S., JR. 11 ACT CO
8 WHEELER ST, SAVANNAH 31405
GALAMBOS, JOHN T. 29 ACT GE
EMORY UNIVERSITY CLINIC, ATLANTA 30322
GALINA, MORTON P. 29 ACT A
993-D JOHNSON FERRY RD NE, ATLANTA 30342
GALL, HENRY 65 ACT PO
PO BOX 502, CAIRO 31728
GALLEMORE, J.L. 06 ACT FP
938 CARROLL ST, PERRY 31069
GALLER, EDWIN J. 22 ACT IM
2054-R LAWRENCEVILLE HWY, OECATUR 30033
GALLIS, ANTHONY H. 15 ACT IM
715 WEST LAKE OR, ATHENS 30606
GALLOWAY, BENJAMIN T. 30 ACT GS
303 MARSHVIEW CONDOMINIUMS, BRUNSWICK 31520
GALLOWAY, GEORGE W., JR. 17 ACT FP
140 RIVER COURT PKY NW, ATLANTA 30328
GALLOWAY, RONALD F. 54 ACT TS
820 ST SEBASTIAN WAY STE 20, AUGUSTA 30902
GALLOWAY, WILLIAM H. 29 ACT OBG
5675 PEACHTREE-DUNWOODY RD, ATLANTA 30342
GALVIN, WILLIAM H. 29 ACT AN
231 GARDEN LN, DECATUR 30030
GAMBRELL, R. DON, JR. 54 ACT OBG,END
903-15TH ST, AUGUSTA 30901
GAMBRELL, W. ELIZABETH 29 ACT IM
217 WILTON DR, DECATUR 30030
GAMMON, JAMES A. 22 ACT OPH
1365 CLIFTON RO, ATLANTA 30322
GAMWELL, JOHN W. 29 ACT ORS
25 PRESCOTT ST NE, ATLANTA 30308
GANN, JOYCE A. 22 ACT OBG
465 WINN WAY STE 100, DECATUR 30030
GANNON, CARMEN 11 ACT IM
PO BOX 10086, SAVANNAH 31412
GARCIA, ALFREDO G. 29 ACT GP
1311 EAST CLEVELAND AVE, EAST POINT 30344
GARCIA, BENITO 02 R FP
6401 NORTH BLOSSOM AVE, TAMPA FL 33614
GARCIA, CASIMIRO S. 29 ACT OBG
340 BOULEVARO NE, ATLANTA 30312
GARCIA, P.F. 29 ACT P
3280 HOWELL MILL RD #202, ATLANTA 30327
GARCIA, RUBEN E. 15 ACT FP
1580 PRINCE AVE, ATHENS 30606
GARCIA, SAMUEL I. 49 ACT OBG
PO BOX 16, MAOISON 30650
GARCIA-SAUL, JOSE A. 29 ACT OBG
993-D JOHNSON FERRY RD #300, ATLANTA 30329

GARDNER, EDWARD C., JR. 15 ACT IM,GE
1077 BAXTER ST, ATHENS 30606
GARDNER, NORMAN P. 69 ACT FP
234 CHEROKEE RD, THOMASTON 30286
GARLAND, JOHN W., III 34 ACT P
664 LANIER PARK DR NE, GAINESVILLE 30505
GARNER, CYLER D. 06 ACT FP
GORDON MEDICAL CENTER, GORDON 31031
GARNER, ROBERT C. 29 ACT PD
47 PEACHTREE PARK DR NE, ATLANTA 30309
GARNER, STEVEN R. 42 ACT FP
MEDICAL CENTER, DUBLIN 31021
GARNER, T. KIRKLAND 29 ACT IM
35 COLLIER RD STE 650, ATLANTA 30309
GARNER, W.R. 34 ACT IM
RTE 12 BOX 163-1, GAINESVILLE 30501
GARNETT, ROBERT L. 47 ACT R
PO DRAWER 2787, COLUMBUS 31902
GARNTO, WILLIAM K. 02 ACT IM,GE
511 NORTH COBB ST, MILLEDGEVILLE 31061
GARRETT, JOHN C. 29 ACT ORS
105 COLLIER RD NW STE 5000, ATLANTA 30309
GARRETT, ROBERT C. 26 ACT FP
PO BOX 427, VIENNA 31092
GARRISON, ALTON F. 54 ACT GS
3623 J DEWEY GRAY CIR ' 205, AUGUSTA 30909
GARRISON, FLETCHER O. 33 ACT FP
912 WAYSIDE ST, CORNELIA 30531
GARRISON, GLEN E. 54 ACT CD
3211 DRESDEN WAY, AUGUSTA 30909
GARRISON, JOSEPH M. 54 ACT AN
812 13TH ST, AUGUSTA 30901
GATEWOOD, T. SCHLEY 61 ACT OBG
205 SOUTH LEE ST, AMERICUS 31709
GATEWOOD, T. SCHLEY, JR. 61 ACT OBG
205 SOUTH LEE ST, AMERICUS 31709
GATTIS, LARRY D. 50 ACT FP
PULASKI PROF BLDG, HAWKINSVILLE 31036
GAUTHIER, P.D. 06 ACT FP
PO BOX 189, JEFFERSONVILLE 31044
GAY, BRIT B., JR. 29 ACT PDR
1405 CLIFTON RD NE, ATLANTA 30322
GAY, FRANCIS M. 19 ACT FP
PO BOX 10, MOULTRIE 31768
GAY, GREGORY L. 54 ACT AN
1303 BIMINI PL, AUGUSTA 30909
GAYTON, JOHNNY L. 36 ACT OPH
216 CORDER RD, WARNER ROBINS 31093
GECKLER, JOHN H. 29 R AN
1731 TRAPNELL CT, ATLANTA 30338
GEDNEY, LEIGH M. 29 S IM
3900 CROWN RD, ATLANTA 30304
GEE, W.N., JR. 56 ACT IM,GE
401 EAST JANE ST, VALDOSTA 31601
GEER, BRUCE R. 29 ACT GE
3250 HOWELL MILL RD NW #200, ATLANTA 30327
GEESLIN, JAMES M. 14 ACT GS
110 WALESKA RD, CANTON 30114
GEIGER, C. LEONARD 34 ACT PTH
PO BOX 1354, GAINESVILLE 30505
GEIGER, HUGH S. 59 ACT
PO BOX 3987, JACKSON 30233
GELBART, ARTHUR O. 54 ACT FP
MEDICAL COLLEGE OF GEORGIA, AUGUSTA 30901
GENT, JACK 31 ACT GS
PO BOX 849, CALHOUN 30701
GENTRY, PAUL D. 10 ACT FP
524 DIXIE ST, CARROLLTON 30117
GEORGE, WILLIAM M., JR. 23 ACT OBG
414 FIFTH AVE, ALBANY 31708
GEORGI, EMIL B. 50 ACT PTH
PO BOX 956, EASTMAN 31023
GERMAN, THOMAS L. 11 ACT ORS
5354 REYNOLDS STE 505, SAVANNAH 31405
GERSHON, CHARLES R. 29 ACT U
340 BOULEVARD NE STE 618, ATLANTA 30312
GERSHON, NATHAN I. 29 ACT OTO
315 BOULEVARD NE, ATLANTA 30312
GERSON, EDWIN STEVEN 16 ACT R
33 UPPER RIVERDALE RD, RIVERDALE 30274
GERSON, GORDON N. 17 ACT ORS
1668 MULKEY RD STE E, AUSTELL 30001
GERTLER, PHILLIP E. 29 R IM
1756 FRIAR TUCK RD NE, ATLANTA 30309
GETMAN, THOMAS A. 56 ACT EM
209 EAST MAIN ST, HAHIRA 31632
GHANI, GHALEB A. 29 ACT AN
1365 CLIFTON RD NE, ATLANTA 30322
GHENT, OLIVER T. 34 ACT R
510 FORREST AVE NW, GAINESVILLE 30501
GHOLSON, A.R. 29 ACT AN
775 KINLOCH NW, ATLANTA 30327
GHORASHI, BIJAN 17 ACT R
5520 GLEN ERROL RD, ATLANTA 30327
GIBBONS, WILLIAM S. 17 ACT ORS
211 CHICOPEE DR, MARIETTA 30060
GIBBS, R.I., JR. 22 ACT IM
2193 NORTH DECATUR RD, DECATUR 30033
GIBSON, FRANK L. 21 ACT GS
PO BOX 525, BAINBRIDGE 31717
GIBSON, HUGH H. 06 ACT OBG
380 HOSPITAL DR, MACON 31201
GIBSON, SAM T. 29 A IM
8800 ROCKVILLE PIKE, BETHESDA MD 20205
GIBSON, WALLACE M. 49 ACT GS
106 NORTH JEFFERSON ST, EATONTON 31024
GIDDENS, I.S. 56 ACT FP
804 WEST MAIN ST, LAKELAND 31635
GIDDENS, RICHARD D. 76 ACT GS
1109 BURLEYSON DR, DALTON 30720
GIESLER, GARNETT J., JR. 68 ACT PUD
303 SMITH ST, LA GRANGE 30240
GILBERT, CARL N. 76 ACT PD
1109 BURLEYSON DR, DALTON 30720
GILBERT, CHARLES A. 22 ACT IM
1462 MONTREAL RD STE 218, TUCKER 30084
GILBERT, CLYDE D. 60 ACT OBG
800 EAST DOYLE ST, TOCCOA 30577
GILBERT, FREDERICK E. 20 ACT PTH
PO BOX 1301, NEWNAN 30264
GILBERT, PETER G. 27 ACT U
HARBIN CLINIC, ROME 30161
GILBERT, ROBERT W., JR. 29 ACT N
105 COLLIER RD STE 2020, ATLANTA 30309
GILBERT, STEWART D. 66 ACT R
PO BOX 388, TIFTON 31794
GILBERT, WARREN 27 ACT FP
HARBIN CLINIC, ROME 30161
GILDINER, KAROL 19 ACT GP
700 SOUTH MAIN ST, MOULTRIE 31768
GILES, BEN J. 29 ACT AN
353 PARKWAY DR NE, ATLANTA 30312
GILES, JACKSON T. 20 ACT OPH
BOX 609, NEWNAN 30264
GILL, SURINDER P.S. 43 ACT R
LUMPKIN COUNTY HOSPITAL, DAHLONEGA 30533
GILLESPIE, CHARLES B. 23 ACT ORS
810 14TH AVE, ALBANY 31708
GILLESPIE, EUGENE J. 29 R D
4525 EAST KINGS POINT CIR NE, ATLANTA 30338
GILLESPIE, JOE I. 54 ACT OTO
1511 ANTHONY RD, AUGUSTA 30904
GILLESPIE, ROBERT H. 29 R OBG
2115 LENOX RD NE, ATLANTA 30324
GILLETT, BRUCE M. 17 ACT N
522 NORTH AVE, MARIETTA 30060
GILLIARD, FRED E. 18 ACT FP
PO BOX 1308, DOUGLAS 31533
GILMORE, THOMAS W., JR. 39 ACT IM
1200 PEACHTREE ST, LOUISVILLE 30434
GILNER, DONALD M. 29 ACT A
960 JOHNSON FERRY RD, ATLANTA 30342
GIMBEL, KENNETH S. 16 ACT CD
29 SW UPPER RIVERDALE RD, RIVERDALE 30274
GIMPEL, AMNON 17 ACT P
1975 NORTH PARK PL STE 200, ATLANTA 30339
GINGREY, JOHN P. 17 ACT OBG
STE F, MARIETTA 30060
GIRARDEAU, JOSEPH L. 29 ACT OBG
105 COLLIER RD NW STE 2030, ATLANTA 30309
GISNESS, ROBERT A. 17 ACT EM
5406 TREELODGE PKY, DUNWOODY 30338
GIVEN, KENNA SIDNEY 54 ACT PS
MEDICAL COLLEGE OF GEORGIA, AUGUSTA 30912
GLADSON, JAMES E. 29 S IM
37 WILLOWICK CT, DECATUR 30034
GLADSTONE, NEIL S. 16 ACT OBG
237 UPPER RIVERDALE RD, RIVERDALE 30274
GLASS, CLARK H. 17 ACT ORS
652 CHURCH ST, MARIETTA 30060
GLASS, LAMAR F. 29 R GS
3180 PALISADES CT, MARIETTA 30067
GLASS, T. FRANKLIN, III 06 ACT DR
770 PINE ST STE L-10, MACON 31201
GLAVEY, CHRISTINE P. 29 ACT D
6500 VERNON WOODS DR NE, ATLANTA 30328
GLAZEBROOK, GEORGE W. 14 ACT GS
110 WALESKA RD, CANTON 30114
GLENN, FRANK D. 08 ACT U
412 NORTHSIDE DR E, STATESBORO 30458
GLENN, T. LAMAR 15 ACT IM
740 PRINCE AVE, ATHENS 30601
GLENN, WADLEY R. 29 ACT GS
35 LINDEN AVE NE, ATLANTA 30308
GLISSON, C. STEADMAN 29 ACT OBG
20 LINDEN AVE NE STE 7-C, ATLANTA 30365
GLOVER, D.H.G. 54 ACT PH
2100 MCDOWELL ST, AUGUSTA 30904
GLOVER, HOWARD C., JR. 20 ACT PD
6 BROWN ST, NEWNAN 30263
GLOVER, N.B. 20 ACT PD
6 BROWN ST, NEWNAN 30263
GLOVER, RIDLEY M. 42 ACT R
PO BOX 793, DUBLIN 31040
GLUCKMAN, RICHARD 17 ACT N
1660 MULKEY RD, AUSTELL 30001
GOBER, H. FRED 29 ACT OBG
960 JOHNSON FERRY RD NE, ATLANTA 30342
GODARD, JOHN E. 10 ACT OPH
160 CLINIC AVE, CARROLLTON 30117
GODBEY, PATRICK E.T. 30 ACT OBG
3226 HAMPTON AVE 'A, BRUNSWICK 31520
GODBEY, RENEE E.W. 30 ACT AN
2444 PARKWOOD DR, BRUNSWICK 31523
GODWIN, JOHN T. 29 ACT PTH
4691 SENTINEL POST RD NW, ATLANTA 30327
GOETZINGER, ROBERT T. 29 ACT OPH
425 FOREST PKY, FOREST PARK 30050
GOICOECHEA, PILAR 02 ACT R
PO BOX 507, HARDWICK 31034
GOLD, HOMER L., JR. 14 ACT FP
110 WALESKA RD, CANTON 30114
GOLD, PERRY 29 A PD
UNIV PLAZA SE/HLTH SVC DPT, ATLANTA 30303
GOLDBERG, AARON S. 68 ACT PD
309 VERNON ST, LA GRANGE 30240
GOLDBERG, RONALD F. 11 ACT ON,IM
5400 SUTLIVE ST STE 3, SAVANNAH 31405
GOLDEN, TERRY D. 29 ACT IM
2045 PEACHTREE RD, ATLANTA 30309
GOLDHAGEN, HAVIVA 19 ACT GP
700 SOUTH MAIN ST, MOULTRIE 31768
GOLDIN, HAROLD W. 27 ACT FP
132 EAST ELM ST, ROCKMART 30153
GOLDKLANG, GERALD A. 29 ACT IM,HEM
5669 PEACHTREE-DUNWOODY RD, ATLANTA 30342
GOLDMAN, ALAN L. 29 ACT GS
11050 CRABAPPLE RD, ROSWELL 30075

GOLDMAN, GILBERT C. 29 ACT D
993-D JOHNSON FERRY RD NE, ATLANTA 30309
GOLDMAN, JOHN A. 29 ACT IM
960 JOHNSON FERRY RD, ATLANTA 30342
GOLDMAN, KENNETH L. 47 ACT GS
905 CENTER ST, COLUMBUS 31901
GOLDMAN, NORMAN I. 47 ACT IM
909 CENTER ST, COLUMBUS 31901
GOLDMAN, ROBERT P. 29 ACT OBG
2788 BAYARD ST STE 201, EAST POINT 30344
GOLDMAN, STEPHEN R. 29 ACT OBG
1938 PEACHTREE RD NW STE 306, ATLANTA 30367
GOLDSAND, CARL S. 16 ACT IM
217 ARROWHEAD BLVD CT C, JONESBORO 30236
GOLDSMITH, ABRAM O. 23 ACT OBG
PO BOX 714, ALBANY 31702
GOLDSMITH, BARRY J. 54 ACT OBG
3614 J DEWEY GRAY CIR STE D, AUGUSTA 30909
GOLDSMITH, HOWARD G. 47 ACT ORS
1920 WARM SPRINGS RD, COLUMBUS 31904
GOLDSTEIN, GOROON T. 29 ACT DR
1170 CLEVELAND AVE, EAST POINT 30344
GOLDSTEIN, JOEL A. 16 ACT PD
29 SW UPPER RIVERDALE RD, RIVERDALE 30274
GOLDSTEIN, MARTIN I. 17 ACT D
3001 SOUTH COBB DR SE, SMYRNA 30080
GOLDSTEIN, ROBERT W. 29 ACT IM
340 BOULEVARD NE STE 214, ATLANTA 30312
GOLLOBIN, GLENN S. 22 I&R
1075-B NORTH JAMESTOWN RD, DECATUR 30033
GOMEZ, FRANK 29 ACT GS
195 UPPER RIVERDALE RD, RIVERDALE 30274
GOMEZ, JULIAN R. 29 ACT P
3280 HOWELL MILL RD STE 236, ATLANTA 30327
GOMEZ, MIGUEL R. 16 ACT AN
MORGAN'S MILL RD RT 2, SENOIA 30276
GONGAWARE, ROBERT O. 11 ACT GS
200 EAST 31ST ST, SAVANNAH 31401
GONGAWARE, THEOOORA L. 11 ACT IM
PO BOX 23089, SAVANNAH 31403
GONZALEZ, ANGELO 29 ACT GS
2741 BAYARD ST, EAST POINT 30344
GONZALEZ, EVANGELIO 10 ACT FP
611 NORTH AVE, VILLA RICA 30180
GONZALEZ, FRANCISCO E. 14 ACT OBG
PO BOX 311, CANTON 30114
GONZALEZ, JOSE M. 02 ACT P
911 RIVERBEND DR, MILLEDGEVILLE 31061
GONZALEZ, PABLO E. 48 ACT AN
45-08 CHERIE GLEN TR, STONE MOUNTAIN 30083
GONZALEZ, VICTOR R. 22 ACT P
1970 CLIFF VALLEY WAY NE, ATLANTA 30329
GOODALE, FAIRFIELD 54 ACT PTH
1120 15TH ST, AUGUSTA 30912
GOODHART, GLENN L. 29 ACT ID
960 JOHNSON FERRY RD STE 243, ATLANTA 30342
GOODLET, JAMES S. 17 ACT U
660 CHEROKEE ST, MARIETTA 30060
GOODMAN, CAREY W., JR. 08 ACT FP
407 ZETTEROWER AVE, STATESBORO 30458
GOODRICH, SAMUEL M. 02 ACT OBG
PO BOX 489, MILLEDGEVILLE 31061
GOODWIN, BURTON D., JR. 11 ACT R
PO BOX 23089, SAVANNAH 31403
GOODWIN, H.A., JR. 27 ACT FP
PO BOX 429, SUMMERVILLE 30747
GOODWIN, HENRY N. 54 ACT ORS
1521 ANTHONY RD, AUGUSTA 30904
GOOLSBY, LOUIS WAYNE 26 I&R FP
110 EAST 13TH AVE, CORDELE 31015
GOOLSBY, SARA L. 70 ACT AN
211 ANDREWS ST, ROSSVILLE 30741
GORDON, J. NICHOLAS 29 ACT OS
3228 HOLLY MILL RUN, MARIETTA 30062
GORDON, LOURDES N. 29 ACT AN
1681 TILLING WAY, STONE MOUNTAIN 30087
GORDON, RICHARD A. 48 ACT R
NEWTON COUNTY HOSPITAL, COVINGTON 30209
GORDON, STEPHEN F. 29 ACT OBG
960 JOHNSON FERRY RD NE, ATLANTA 30342
GORDON, STEPHEN W. 29 A PS
5440 ORLEY TERR, COLLEGE PARK 30349
GORDON, WALTER C. 23 ACT GS
401-A SOUTH MADISON ST, ALBANY 31701
GOSS, CHRISTOPHER C. 26 R FP
ASHBURN 31714
GOSS, WOODROW 26 ACT FP
345 EAST WASHINGTON ST, ASHBURN 31714
GOTAY, HECTOR 34 ACT N
592 MEDICAL PARK DR, GAINESVILLE 30501
GOTLIEB, EDWARD 22 ACT ADL
5565-D MEMORIAL DR, STONE MOUNTAIN 30083
GOTLIEB, JAQUELIN 22 ACT PD
5565-D MEMORIAL DR, STONE MOUNTAIN 30083
GOTTLIEB, GEORGE R. 22 ACT A
365 WINN WAY STE 120, DECATUR 30030
GOTTSCHALK, ROBERT B., SR. 11 R GS
BOX 40 BAYNARD PL RD, HILTON HEAD SC 29928
GOULD, MARK A. 17 ACT P
3188 ATLANTA RD, SMYRNA 30080
GOWDER, GEORGE D., JR. 34 ACT FP
PO BOX 726, BLAIRSVILLE 30512
GOWEN, JAMES F. 30 ACT OBG
3226 HAMPTON AVE-A, BRUNSWICK 31520
GOWER, W.J. 69 ACT FP
806 AVALON RD, THOMASTON 30286
GOWER, WILLIAM J. 29 ACT IM
6500 VERNON WOODS DR STE A-2, ATLANTA 30328
GRABLOWSKY, OSCAR M. 29 ACT CRS
315 BOULEVARD NE STE 220, ATLANTA 30312
GRACE, KENNETH O. 68 ACT GS
206 CHURCH ST, LA GRANGE 30240
GRACIAA, GUIDO F. 02 ACT N
912 RIVERBEND RD, MILLEDGEVILLE 31061
GRADY, DONALD F. 29 ACT NS
993-F JOHNSON FERRY RD, ATLANTA 30342
GRADY, EDGAR D. 29 ACT GS,ND
181-A UPPER RIVERDALE RD, RIVERDALE 30274
GRAHAM, HAMLIN 54 ACT ORS
1021 15TH ST STE 8, AUGUSTA 30901
GRAHAM, SAM D. 29 ACT U
1365 CLIFTON RD NE, ATLANTA 30322
GRAHAM, THOMAS C. 20 ACT OBG
PO BOX 609, NEWNAN 30264
GRAHAM, WILLIAM L. 47 ACT R
PO DRAWER 2787, COLUMBUS 31902
GRAMLING, Z.W. 54 ACT AN
TALMADGE MEMORIAL HOSPITAL, AUGUSTA 30902
GRANT, ALFRED A. 06 ACT P
770 PINE ST STE 530, MACON 31201
GRANT, EDWIN H. 10 ACT R
605 DIXIE ST, CARROLLTON 30117
GRANT, JESSE R., JR. 06 ACT FP
235 MEDICAL CT, FORSYTH 31029
GRANT, JOHN R. 23 ACT OTO
804-14TH AVE, ALBANY 31708
GRANT, LARRY W. 06 ACT IM
726 FIRST ST, MACON 31201
GRANT, R. PEERY 22 ACT PYA,P
1493 LAVISTA RD NE, ATLANTA 30324
GRANT, ROBERT C. 34 ACT IM
174 PRIOR ST NE, GAINESVILLE 30501
GRANTHAM, C.G. 06 ACT AN
RTE 1 PO BOX 352, GRAY 31032
GRANTHAM, V.J. 36 ACT FP
PO BOX 1088, FORT VALLEY 31030
GRAVANIS, MICHAEL B. 29 ACT PTH
EMORY UNIV SCH OF MEDICINE, ATLANTA 30322
GRAVES, RAPHAEL K. 29 ACT PTH
1000 JOHNSON FERRY RD NE, ATLANTA 30345
GRAY, A. RICHARD 27 ACT GS
310 WEST SIXTH ST, ROME 30161
GRAY, J.D. 54 ACT IM
3623 J DEWEY GRAY CIR ' 209, AUGUSTA 30909
GRAY, O.L., JR. 54 ACT FP
1224 WEST MARKS CHURCH RD, AUGUSTA 30909
GRAY, SAMUEL H. 22 ACT GS
4555 NORTH SHALLOWFORD RD, ATLANTA 30338
GREEN, BRUCE G. 29 ACT U
6500 VERNON WOODS DR NE, ATLANTA 30328
GREEN, CHARLES G. 09 ACT FP
222 SIXTH ST, WAYNESBORO 30830
GREEN, EDMOND W. 29 ACT FP
3383 STEWART AVE, HAPEVILLE 30354
GREEN, GEORGE F. 49 ACT FP
525 SPRING ST, SPARTA 31087
GREEN, JAMES A. 15 R GS
146 DEARING ST, ATHENS 30605
GREEN, MARGARET GRAHAM ORR 54 ACT OPH
1514 ANTHONY RD, AUGUSTA 30904
GREENBERG, IRVING L. 29 ACT GS
29 LINDEN AVE NUE STE 20-A, ATLANTA 30365
GREENBERG, JOEL I. 29 ACT OBG
2550 WINDY HILL RD STE 206, MARIETTA 30067
GREENBLATT, ROBERT B. 54 ACT OBG
903 - 15TH ST, AUGUSTA 30902
GREENE, DAVID 29 ACT DR
35 LINDEN AVE, ATLANTA 30308
GREENE, RALPH R. 70 ACT FP
2007 OLD LAFAYETTE RD, FT OGLETHORPE 30742
GREENHOOD, GARY P. 17 ACT IM
833 CAMPBELL HILL ST #107, MARIETTA 30090
GREENWALD, HERBERT S., JR. 06 ACT OPH
380 HOSPITAL DR, MACON 31201
GREENWALO, LLOYD V. 17 ACT R
70 TOWER RD, MARIETTA 30060
GREENWELL, KEVIN R. 06 I&R FP
784 SPRING ST, MACON 31201
GREER, CHARLES C. 26 ACT OPH
1702 EAST 20TH AVE, CORDELE 31015
GREER, MACK V. 56 ACT FP
VSC INFIRMARY, VALDOSTA 31698
GREGG, PATRICIA M. 14 ACT AN
307 HEMBREE HILL RD, CANTON 30114
GREGORY, HUGH H. 29 ACT GS
735 PIEDMONT AVE NE, ATLANTA 30365
GREGORY, J. MICHAEL 15 ACT U
195 KING AVE, ATHENS 30601
GREGORY, JAMES R. 76 ACT OBG
1109 BURLEYSON DR STE A, DALTON 30720
GREGORY, JOHN E. 47 ACT PTH
1060 STANDING BOY CT, COLUMBUS 31904
GRIFFETH, JOE L. 37 ACT FP,GS
MEDICAL CENTER CLINIC, COMMERCE 30529
GRIFFIN, BASIL M., JR. 29 ACT ORS
993 JOHNSON FERRY RD NE, ATLANTA 30342
GRIFFIN, E. RAWSON, III 47 DE4 FP
18 WEST WAINWRIGHT, POQUOSON VA 23662
GRIFFIN, EDMOND I. 29 ACT D
5669 PEACHTREE DUNWOODY RD, ATLANTA 30342
GRIFFIN, HOWARO A., JR. 72 ACT R
PO BOX 938, WAYCROSS 31501
GRIFFIN, JACK T. 47 ACT NS
2009 WARM SPRINGS RD, COLUMBUS 31904
GRIFFIN, JOHN B., JR. 22 ACT P
1711-B UPPERGATE DR NE, ATLANTA 30307
GRIFFIN, JOHN M. 29 ACT PS
3280 HOWELL MILL RD STE 111, ATLANTA 30327
GRIFFIN, JOSEPH W., JR. 54 ACT IM,GE
MEDICAL COLLEGE OF GEORGIA, AUGUSTA 30912
GRIFFIN, LOUIE H., JR. 54 ACT GS
1430 HARPER ST, AUGUSTA 30902
GRIFFIN, SHELLEY A. 09 ACT PD
304 JONES AVE, WAYNESBORO 30830
GRIFFIN, WARREN L., JR. 06 ACT OTO
800 FIRST ST, MACON 31201
GRIFFITHS, GLENN C. 47 S FP
MARTIN ARMY HOSPITAL, FT BENNING 31905

GRIMES, W.H., JR. 29 ACT OBG
5675 PEACHTREE-DUNWOODY RD, ATLANTA 30342
GRINDON, ALFRED J. 29 ACT BLB,PTH
1925 MONROE DR NE, ATLANTA 30324
GRINER, WALLACE 47 ACT EM
5614 ROARING BRANCH RD, COLUMBUS 31904
GRIST, WILLIAM J. 29 ACT OTO,HNS
1365 CLIFTON RD, ATLANTA 30322
GROSS, GAIL K. 29 ACT OBG
5675 PEACHTREE DUNWOODY RD, ATLANTA 30342
GROSS, LEON R. 29 ACT OPH
490 PEACHTREE ST STE 365-C, ATLANTA 30308
GROSS, PETER R. 29 ACT IM
384 PEACHTREE ST NE, ATLANTA 30308
GROSSMAN, CONRAO P. 06 ACT OBG
380 HOSPITAL DR, MACON 31201
GROSSMAN, GILBERT O. 29 ACT IM
25 PRESCOTT ST NE, ATLANTA 30308
GROVES, ROBERT H. 23 ACT FP
PO BOX 1908, ALBANY 31703
GROW, WILLIAM R. 56 ACT IM
PO BOX 3115, VALDOSTA 31602
GRUBB, WILLIAM G. 30 ACT IM
2705 WILDWOOD DR, BRUNSWICK 31520
GRUBBS, JOHN E. 27 ACT N
1825 MARTHA BERRY BLVD, ROME 30161
GRUENTZIG, ANOREAS R. 29 ACT CD
1364 CLIFTON RD NE, ATLANTA 30322
GRUMET, ROSS R. 29 ACT P
300 BOULEVARD NE, ATLANTA 30312
GUOE, A.V. 29 ACT AN
29 MOORGATE SQUARE NW, ATLANTA 30327
GUERRY, RODERICK L. 11 ACT PTH
PO BOX 9787, SAVANNAH 31402
GUFFIN, THOMAS N. 29 ACT GS
461 KING ARNOLD ST, HAPEVILLE 30354
GUILL, MARGARET F. 54 ACT AL
2247 PICKENS RD, AUGUSTA 30904
GUILLEBEAU, F. OEMPSEY 23 ACT IM
PO BOX 288, ALBANY 31702
GULLEN, WARREN H. 54 ACT ID
MEDICAL COLLEGE OF GEORGIA, AUGUSTA 30912
GULLETT, CHARLES C. 29 ACT AM
PO BOX 20787, ATLANTA 30320
GUNN, JOSEPH B. 34 ACT PD
247 SOUTH ENOTA DR, GAINESVILLE 30505
GUR-LAVI, MEIR 17 ACT RHU
1668 MULKEY RD STE A, AUSTELL 30001
GURSEL, SEZAI 47 ACT PTH
PO BOX 7000, COLUMBUS 31995
GUSSACK, HAROLO A. 29 ACT IM
478 PEACHTREE ST NE, ATLANTA 30309
GUY, ERNEST P. 22 ACT AN
755 COLUMBIA DR STE 413, DECATUR 30030
GUYTON, ROBERT A. 29 ACT TS
25 PRESCOTT ST NE, ATLANTA 30308
GUZMAN, GERARDO H. 25 ACT GP
BOX 729, SWAINSBORO 30401
GUZMAN, MARGARITA 43 ACT GS
PO BOX 777, DAHLONEGA 30533
GUZZAROO, MARCIA B. 36 ACT PD
116 SOUTH HOUSTON RD, WARNER ROBINS 31093

H

HAAS, JOSEPH A. 22 ACT U
500 IRVIN CT STE C-230, DECATUR 30030
HAAS, MELVYN L. 54 ACT N
820 ST SEBASTIAN WAY STE 5-C, AUGUSTA 30902
HABER, JEROLD A. 29 ACT ORS
5667 PEACHTREE DUNWOODY RD, ATLANTA 30342
HABERMAN, GEORGE G. 11 ACT GS
511 ARLINGTON RD, SAVANNAH 31406
HABERMAN, MICHAEL A. 29 ACT P
3280 HOWELL MILL RD STE 230, ATLANTA 30327
HACKER, MORTIMER 29 S GP
80 TENTH ST NE, ATLANTA 30309
HACKNEY, J.F. 29 ACT PH
1611 MILL ACRES DR SW, ATLANTA 30311
HADLEY, ELIZABETH 16 ACT R
PO BOX 699, RIVERDALE 30236
HAGEN, ARTHUR R. 30 ACT ORS
3010 HAMPTON AVE, BRUNSWICK 31520
HAGLER, ABIGAIL 29 I&R IM
669 DURANT PL, ATLANTA 30308
HAGLER, JAMES R., SR. 47 ACT GP
PO BOX 436, BUENA VISTA 31803
HAGLER, MARY ANNE TYLER 54 ACT FP
999 HIGHLAND AVE, AUGUSTA 30904
HAGLER, WILLIAM S. 29 ACT OPH
2004 PEACHTREE RD NW, ATLANTA 30309
HAGOOD, M. FELTON 17 ACT CRS
805 CAMPBELL HILL ST, MARIETTA 30060
HAGOOD, M.M. 17 ACT GS
50 PLAZA WAY STE E, MARIETTA 30060
HAGOOO, RICHARD M. 17 ACT OBG
1790 MULKEY RD #5, AUSTELL 30001
HAHN, EDWARD E. 11 ACT PTH
11705 MERCY BLVD, SAVANNAH 31406
HAILE, KENNETH L., JR. 17 ACT TR
PO BOX 3333, MARIETTA 30061
HAILEY, CHENAULT W. 29 ACT D
478 PEACHTREE ST NE, ATLANTA 30308
HAJ-MURAD, M. RAMZY 17 ACT U
4760 AUSTELL RD, AUSTELL 30001
HAJOSY, RALPH W. 59 ACT ORS
616 SOUTH EIGHTH ST, GRIFFIN 30223
HAKIM, FAEZ 23 ACT PTH
2206 WESTMORELAND DR, ALBANY 31707
HALDEMAN, LARRY W. 17 ACT PUD
833 CAMPBELL HILL ST, ' 200, MARIETTA 30090
HALEY, WILLIAM E. 30 ACT IM
2444 PARKWOOD DR, BRUNSWICK 31520
HALKOS, ALEXANDER A. 22 ACT IM
755 COLUMBIA DR STE 912, DECATUR 30030
HALL, ARTHUR L. 68 ACT FP
303 SMITH ST, LA GRANGE 30240
HALL, GEORGE W. 17 ACT R
3950 AUSTELL RD, AUSTELL 30001
HALL, H. LEE 29 ACT P
1970 CLIFF VALLEY WAY NE, ATLANTA 30329
HALL, JOHN C. 29 ACT IM
960 JOHNSON FERRY RD NE, ATLANTA 30342
HALL, MAXWELL F., JR. 17 ACT R
70 TOWER RD, MARIETTA 30060
HALL, PAMELA P. 68 ACT FP
303 SMITH ST, LA GRANGE 30240
HALL, STANLEY W., JR. 68 ACT OPH
303 SMITH ST, LA GRANGE 30240
HALL, W.D. 31 ACT GS
SOUTH WALL ST, CALHOUN 30701
HALLBERG, STEVEN C. 17 ACT IM
PO BOX 39, AUSTELL 30001
HALLENBORG, BRUCE P. 17 ACT N
3903 SOUTH COBB DR, SMYRNA 30080
HALLMAN, B.L. 29 A IM
69 BUTLER ST SE, ATLANTA 30303
HALLMAN, HELEN W. 29 R AN
RTE 2 BOX 686, REMLAP AL 35133
HALLUM, ALTON V. 29 ACT OPH
3280 HOWELL MILL RD NW #207, ATLANTA 30327
HALPER, ROBERT M. 29 ACT DR
35 COLLIER RD NW STE 305, ATLANTA 30309
HALTIWANGER, EARL 29 S U
1670 CLAIRMONT RD NE, DECATUR 30033
HAM, O. EMERSON, JR. 11 ACT N
4 JACKSON BLVD, SAVANNAH 31405
HAMES, CURTIS G. 08 ACT IM
2 NEWTON ST, CLAXTON 30417
HAMFF, L. HARVEY 29 ACT IM
478 PEACHTREE ST NE, ATLANTA 30308
HAMILTON, NEWELL M. 30 ACT PD
2601 PARKWOOD DR #2, BRUNSWICK 31520
HAMILTON, VIRGINIA D. 04 ACT PH
204 WEST CHEROKEE AVE, CARTERSVILLE 30120
HAMM, WILLIAM G. 29 ACT PS
3280 HOWELL MILL RD NW, ATLANTA 30327
HAMMAD, W. DAVIO 29 ACT PD
315 BOULEVARD NE STE 428, ATLANTA 30312
HAMMETT, H. HILT, JR. 68 ACT OTO
HAMMETT BLDG, LA GRANGE 30240
HAMMONO, DEWEY 31 ACT FP
TENNESSEE ST, FAIRMOUNT 30139
HAMMONO, WILLIAM J. 05 ACT FP,GS
PO BOX 929, FITZGERALD 31750
HAMMONOS, RICHARD LEE 17 ACT FP
4760 AUSTELL RD SW, AUSTELL 30001
HAMMONOS, WILLIAM D. 29 ACT AN
1365 CLIFTON RD NE, ATLANTA 30322
HANAFI, MAGDI 17 ACT OBG
300 BOULEVARD NE, ATLANTA 30312
HANBERRY, RICHARO L. 06 ACT OBG
657 HEMLOCK ST, MACON 31201
HANCOCK, CARL V., JR. 23 ACT U
810-13TH AVE, ALBANY 31701
HANCOCK, CHARLES I. 29 ACT ORS
315 BOULEVARD NE STE 312, ATLANTA 30312
HANCOCK, ROBERT K. 29 ACT OBG
490 PEACHTREE ST NE, ATLANTA 30308
HANCOCK, S.L. 65 ACT US
35 14TH AVE NW, CAIRO 31728
HANOELSMAN, STUART 29 ACT IM
960 JOHNSON FERRY RD NE, ATLANTA 30342
HANES, O. EUGENE 29 ACT IM
2315 LIFE OF GEORGIA TOWER, ATLANTA 30308
HANEY, MICHAEL J. 19 ACT GS
3004 SECOND ST SE, MOULTRIE 31768
HANEY, MICHAEL L. 65 ACT OPH
808 GORDON AVE, THOMASVILLE 31792
HANKEY, DANIEL D. 29 R IM
490 PEACHTREE ST NE, ATLANTA 30308
HANKS, JACK B. 12 ACT FP
33 CHESTNUT ST, ELBERTON 30635
HANKS, JEFFERSON D., JR. 27 ACT R
1104 MARTHA BERRY BLVD, ROME 30161
HANNA, MAGDI BISHAY 47 ACT FP
5612 WHITESVILLE RD, COLUMBUS 31904
HANSEN, ROBERT F. 29 S PH
2 EMMA LN NE, ATLANTA 30305
HANSON, THOMAS A. 54 ACT PD
3623 J DEWEY GRAY CIR ' 203, AUGUSTA 30909
HANZLICK, RANOY L. 29 ACT FOP
50 COCA COLA PL SE, ATLANTA 30303
HARBIN, BANNESTER L., JR. 27 ACT GS
HARBIN CLINIC, ROME 30161
HARBIN, BUFORD G. 27 ACT PUD
1825 MARTHA BERRY BLVD, ROME 30161
HARBIN, LESTER 27 ACT GS
HARBIN CLINIC, ROME 30161
HARBIN, R.M., JR. 27 ACT GS
814 EAST 2ND AVE #4, ROME 30161
HARBIN, ROBERT L. 27 ACT OPH
1825 MARTHA BERRY BLVD, ROME 30161
HARBIN, THOMAS S. 27 ACT OPH
HARBIN CLINIC, ROME 30161
HARBIN, THOMAS S., JR. 29 ACT OPH
2004 PEACHTREE RD NW, ATLANTA 30309
HARBIN, W.P., JR. 27 ACT IM
HARBIN CLINIC, ROME 30161
HARBIN, WILLIAM P. 27 ACT R
1104 MARTHA BERRY BLVD, ROME 30161
HARBOUR, JOHN H. 17 ACT IM
696 CONCORD RD SE, SMYRNA 30080
HARDCASTLE, WILLIAM R. 22 ACT GS
487 WINN WAY STE 103, DECATUR 30030
HARDEMAN, FRANK, JR. 11 ACT FP
3025 BULL ST, SAVANNAH 31405

HARDEN, TIMOTHY, JR. 22 ACT IM
711 CHURCH ST, DECATUR 30030
HARDEN, W.E. 30 ACT R
3010 HAMPTON AVE, BRUNSWICK 31520
HARDIN, FREDERICK F. 29 ACT D
105 COLLIER RD NW STE 4070, ATLANTA 30309
HARDISON, JOSEPH E. 29 S IM
1670 CLAIRMONT RD, DECATUR 30033
HARDMAN, BILLY S. 34 ACT GYN
420 BROAD ST SE, GAINESVILLE 30501
HARDMAN, JOHN B. 29 ACT CHP
2151 PEACHFORD RD, ATLANTA 30338
HARDMAN, WILLIAM J. 15 ACT OBG
740 PRINCE AVE, ATHENS 30601
HARDY, WALLACE E. 22 ACT OBG
5 LAVISTA PERIMETER OFC PK, TUCKER 30084
HARGREAVES, HILARY K. 22 ACT PTH
DEKALB GENERAL HOSPITAL, ATLANTA 30033
HARLEY, EUGENE L. 17 ACT IM
696 CONCORD RD SE, SMYRNA 30080
HARMON, JAMES C. 33 ACT FP
553 SOUTH MAIN ST, CORNELIA 30531
HARMON, JOHN D. 54 ACT GS,OTO
MEDICAL COLLEGE OF GA CJ 357, AUGUSTA 30912
HARPER, BYRON F., JR. 29 ACT IM
2739 BAYARD ST, EAST POINT 30344
HARPER, HARRY T., III 54 ACT CD
820 ST SEBASTIAN WAY STE 2-A, AUGUSTA 30902
HARPER, HARRY T., JR. 54 ACT IM
820 ST SEBASTIAN WAY STE 2-A, AUGUSTA 30902
HARPER, HENRY W., JR. 06 ACT AN
742 CAPTAIN KELL DR, MACON 31204
HARPER, HERBERT S. 54 ACT PD
1430 HARPER ST BLDG C STE 2, AUGUSTA 30910
HARPER, JOHN T. 29 ACT ORS
340 BOULEVARD NE STE 608, ATLANTA 30312
HARPER, KENNETH E. 06 I&R GS
MEDICAL CENTER OF CENTRAL GA, MACON 31208
HARPER, MEREOITH 18 ACT OBG
PO BOX 1366, DOUGLAS 31533
HARPER, ROBERT M. 17 ACT D
114 CHERRY ST STE E, MARIETTA 30090
HARPER, WILLIAM F. 23 ACT GS
810 13TH AVE, ALBANY 31701
HARPER, WILLIAM M., IV 47 ACT U
1021 TALBOTTON RD, COLUMBUS 31904
HARPER, WILLIAM N. 29 ACT IM
75 PIEDMONT AVE NE, ATLANTA 30303
HARREL, JOHN A., JR. 22 ACT PH
2701 NORTH DECATUR RD, DECATUR 30033
HARRELL, E.L. 75 ACT US
RTE 4 BOX 424, JESUP 31545
HARRIES, JOHN O. 06 ACT AN
PO BOX 7605, MACON 31209
HARRIS, BOAZ 29 ACT P
3280 HOWELL MILL RD STE 338, ATLANTA 30327
HARRIS, O.Q., III 19 ACT ORS
111 30TH AVE SE, MOULTRIE 31768
HARRIS, HERSCHEL B. 15 R GP
ATHENS GENERAL HOSPITAL, ATHENS 30601
HARRIS, J. FRANK 29 ACT IM
384 PEACHTREE ST NE, ATLANTA 30308
HARRIS, J. HENRY WALKER 47 ACT R
2860 CROMWELL DR, COLUMBUS 31906
HARRIS, JAMES B. 29 ACT OBG
210 AUBURN AVE NE STE 6, ATLANTA 30303
HARRIS, JOHN A. 11 ACT IM
2203 ABERCORN ST, SAVANNAH 31401
HARRIS, ROBERT M. 15 ACT P
PO BOX 8046, ATHENS 30603
HARRIS, STERLING A. 13 ACT R
BOX 460, BUFORD 30518
HARRIS, T.A. 22 ACT OBG
5040 SNAPFINGER WOODS DR, DECATUR 30035
HARRIS, WESLEY W. 28 ACT FP
350 CHURCH ST, ROYSTON 30662

HARRISON, CHARLES E., JR. 29 ACT IM
35 COLLIER RD NW STE 350, ATLANTA 30309
HARRISON, CLYDE C., JR. 16 ACT GS
1019 ASTOR AVE, FOREST PARK 30050
HARRISON, EUGENE O. 29 ACT GS
340 BOULEVARD NE, ATLANTA 30312
HARRISON, F.N. 54 ACT OBG
1021 15TH ST, AUGUSTA 30901
HARRISON, GEORGE I. 17 ACT OTO
833 CAMPBELL HILL ST, MARIETTA 30090
HARRISON, HAROLD B. 06 ACT IM,GE
836 ORANGE TERR, MACON 31201
HARRISON, J.HAROLD 29 ACT CD
490 PEACHTREE ST NE, ATLANTA 30308
HARRISON, JACOB R., JR. 76 ACT OBG
1108 PROFESSIONAL BLVD, DALTON 30720
HARRISON, JOHN R. 22 ACT FP
5372 PEACHTREE RD, CHAMBLEE 30341
HARRISON, WALTER E. 19 ACT FP
711 SOUTH MAIN ST, MOULTRIE 31768
HARRISON, WILLIAM V. 24 ACT GP
100 PASSIEU CIR, FOLKSTON 31537
HARTLAGE, PATRICIA L. 54 ACT OS
MEDICAL COLLEGE OF GEORGIA, AUGUSTA 30902
HARTLEY, JOHN H., JR. 29 ACT PS
3280 HOWELL MILL RD STE 111, ATLANTA 30327
HARTLEY, S.T. 16 ACT EM
33 SW UPPER RIVERDALE RD, RIVERDALE 30274
HARTMAN, SANFORD S. 22 ACT RHU
2754 N DECATUR RD STE 111, DECATUR 30033
HARTMAN, TED E. 22 ACT FP
5040 SNAPFINGER WOODS DR, DECATUR 30032
HARTRAMPF, CARL R., JR. 29 ACT PS
993-C JOHNSON FERRY RD NE, ATLANTA 30342
HARVEY, DAVID N., III 36 ACT PD
116 SOUTH HOUSTON RD, WARNER ROBINS 31093
HARVEY, OENNIS W. 17 ACT AN
1001 THORNTON RD, LITHIA SPRINGS 30057
HARVEY, JAMES S. 43 ACT FP
403 HAWKINS ST, DAHLONEGA 30533
HARVEY, JOHN S. 29 ACT GS
960 JOHNSON FERRY RD NE, ATLANTA 30342
HARVEY, LOUIS R. 74 ACT FP
PO BOX 383, SANDERSVILLE 31082
HARWOOD, ROBERT A. 29 ACT DR
1000 JOHNSON FERRY RD NE, ATLANTA 30338
HASAN, KHALIL A. 06 ACT GS
3854 RIVERSIDE DR, MACON 31210
HASSINGER, JOHN T. 22 ACT GS
497 WINN WAY STE A-130, DECATUR 30030
HASTINGS, E.V. 54 ACT PTH
2260 WRIGHTSBORO RD, AUGUSTA 30910
HASTY, JEFFREY HARDING 17 ACT PD
4001 CANTON HWY STE 6, MARIETTA 30066
HASTY, LEWIS B. 29 ACT OBG
1702 CLEVELAND AVE, EAST POINT 30344
HATCH, JOSEPH C. 56 ACT GS
SEMINOLE SQ COND, SEMINOLE FL 33542
HATCHER, CHARLES R. 29 ACT GS
EMORY UNIVERSITY CLINIC, ATLANTA 30322
HATCHER, MILFORD B. 06 ACT GS
781 SPRING ST, MACON 31201
HATCHER, ROBERT A. 29 A
393 WEST WESLEY RD NW, ATLANTA 30305
HATFIELD, THEODORE R. 68 ACT OM
PO BOX 71, WEST POINT 31833
HATHCOCK, WILLIAM C. 29 ACT OTO
401 PEACHTREE ST NE, ATLANTA 30308
HATTAWAY, JAMES R. 23 ACT U
810 13TH AVE, ALBANY 31701
HAUCK, A.E. 29 ACT GS
478 PEACHTREE ST NE, ATLANTA 30308
HAUCK, LORAN D. 31 ACT IM
RED BUD RD, CALHOUN 30701
HAUN, COSMO L. 29 ACT R
EMORY UNIVERSITY CLINIC, ATLANTA 30322

HAVERTY, J. RHODES 29 ACT PD
33 GILMER ST, ATLANTA 30303
HAWK, JUOSON L., JR. 29 ACT PD
1001 JOHNSON FERRY RD NE, ATLANTA 30363
HAWK, THOMAS H., JR. 15 ACT GS
740 PRINCE AVE, ATHENS 30601
HAWKINS, JOHN C. 06 ACT IM
800 FIRST ST STE 320, MACON 31201
HAWKINS, KATRINE RAWLS 55 ACT FP
PO BOX 518, SYLVANIA 30467
HAY, S.H. 60 ACT IM
EAST DOYLE ST, TOCCOA 30577
HAYES, T. WILLIAM 66 ACT OTO
PO BOX 1565, TIFTON 31794
HAYES, THOMAS E. 70 ACT GS
200 DOCTORS BLDG, FT OGLETHORPE 30742
HAYES, WILLIAM H. 47 ACT FP
2300 MANCHESTER EXPY, COLUMBUS 31904
HAYNES, RALEIGH R. 66 ACT AN
1607 JOHN OPP DR, TIFTON 31794
HAYNES, RALPH L. 29 ACT PUD
250 RIVERWOOD CT, ATLANTA 30328
HAYS, WILLIAM A., JR. 15 ACT P,CHP
PO BOX 712, ATHENS 30603
HAYSMAN, MELVIN L. 11 ACT A,IG
5400 WATERS AVE, SAVANNAH 31404
HAZELHURST, W. OERREL 06 ACT IM
765 SPRING ST, MACON 31201
HEAD, O.L., JR. 69 ACT FP
PO BOX 591, THOMASTON 30286
HEADLEY, WILLIAM MCKENDREE 02 ACT GS
811 NORTH COBB ST, MILLEDGEVILLE 31061
HEALEY, KENNETH W. 54 I&R OBG
1706 KINGS WOOD DR, AUGUSTA 30904
HEARD, JOHN P. 22 ACT FP
755 COLUMBIA DR STE 333, DECATUR 30030
HEARD, WILLIAM C. 42 ACT OTO
ERIN OFFICE PK #22, DUBLIN 31021
HEARIN, OAVIO L. 29 ACT D
3158 MAPLE DR NE, ATLANTA 30305
HEATH, GEORGE S. 72 ACT FP
PO BOX 1909, WAYCROSS 31501
HEATH, HEZEKIAH K., JR. 72 ACT US
PO BOX 1909, WAYCROSS 31501
HEATH, TIM RAY 29 ACT GS
3280 HOWELL MILL RD STE 327, ATLANTA 30327
HECHT, HOWARD L. 29 ACT ORS
5667 PEACHTREE-DUNWOODY RD, ATLANTA 30342
HEFFERNAN, J. ANTHONY, JR. 11 ACT FP
20 MEDICAL ARTS CENTER, SAVANNAH 31405
HEGE, DARVIN 29 ACT P
2150 PEACHFORD RD STE H, ATLANTA 30338
HEIDARY, DARIUSH H. 11 ACT CDS,TS
5112 PAULSEN ST, SAVANNAH 31405
HEILMAN, RICHARD B. 29 ACT OM
PO BOX 49447, ATLANTA 30359
HEIN, DAVID E. 29 ACT IM
340 BOULEVARD NE, ATLANTA 30312
HELLENGA, IRVING D. 60 ACT FP
TOCCOA CLINIC, TOCCOA 30577
HELMS, WILLIAM C. 29 ACT OBG
35 COLLIER RD NW, ATLANTA 30309
HELTON, WILLIAM S. 74 ACT FP
522 WASHINGTON AVE, SANDERSVILLE 31082
HEMMER, JOHN L., JR. 34 ACT ORS
660-A LANIER PARK DR NE, GAINESVILLE 30505
HEMPHILL, J. MICHAEL 11 ACT N
5105 PAULSEN ST STE 111, SAVANNAH 31405
HENDEE, ARMAND E. 29 ACT OBG
EMORY UNIVERSITY CLINIC, ATLANTA 30322
HENDERSON, CHARLES A. 29 ACT ON
105 COLLIER RD NW, ATLANTA 30309
HENDERSON, CHARLES T. 17 ACT GS
737 CAMPBELL HILL ST, MARIETTA 30060
HENDERSON, KENNETH C. 06 ACT PD
777 HEMLOCK ST, MACON 31201

HENDERSON, WARREN J., JR. 68 ACT IM
303 SMITH ST, LA GRANGE 30240
HENDLEY, ROBERT L. 29 ACT OPH
11050 CRABAPPLE RD STE 107, ROSWELL 30075
HENDRICK, A.G. 36 ACT FP
BOX 32, PERRY 31069
HENDRICKS, WILLIS M. 68 ACT OBG
303 SMITH ST, LA GRANGE 30240
HENDRIX, ARTHUR M. 14 R FP
465 WEST CLOVERHURST AVE, ATHENS 30606
HENDRIX, MAECDNAS B. 47 ACT ORS
1920 WARM SPRINGS RD, COLUMBUS 31904
HENDRIX, NANCY C. 15 ACT PD
1010 PRINCE AVE, ATHENS 30606
HENDRIX, STEPHEN G. 11 ACT PUD
PO BOX 23677, SAVANNAH 31403
HENDRIX, VERNON J. 29 ACT OBG
960 JOHNSON FERRY RD NE, ATLANTA 30342
HENDRY, CHARLES H. 16 ACT P
3540 COCHISE DR NW, ATLANTA 30339
HENDRY, KATHERINE M. 72 R FP
PO BOX 408, BLACKSHEAR 31516
HENNESSY, DANIEL J. 29 ACT OPH
3280 HOWELL MILL RD STE 124, ATLANTA 30327
HENRY, GEORGE M. 06 ACT P
596 ARLINGTON PL, MACON 31201
HENRY, GEORGE T. 59 ACT FP
TAYLOR ST, BARNESVILLE 30204
HENRY, J. LAMONT 29 ACT IM
650 MOORES MILL RD #4, ATLANTA 30327
HENRY, WAIGHTS, III 17 ACT GS
805 CAMPBELL HILL ST, MARIETTA 30090
HENSLEY, E.A. 54 R GP
1259 PINE LOG RD, CONYERS 30207
HENSLEY, E.R. 54 ACT EM
2431 PEACH ORCHARD RD, AUGUSTA 30906
HENSON, PAUL E., JR. 76 ACT U
1109 BURLEYSON DR, DALTON 30720
HERD, PAUL A. 29 ACT IM
35 COLLIER RD NW, ATLANTA 30309
HERNANDEZ, FERNANDO G. 36 ACT IM
1011 NORTH HOUSTON RD, WARNER ROBINS 31093
HERNANDEZ, R.J. 29 ACT AN
353 PARKWAY DR NE, ATLANTA 30312
HERNDON, E. GARLAND, JR. 29 ACT IM
1440 CLIFTON RD NE, ATLANTA 30322
HERRERA, PASCUAL 17 ACT GS
222 CHEROKEE ST NE, MARIETTA 30060
HERRIN, E.V. 15 ACT OBG
740 PRINCE AVE, ATHENS 30601
HERRING, DAVEY D. 06 I&R GS
342 CORBIN AVE, MACON 31204
HERRING, JOHN S., JR. 06 ACT OBG
675 NEW ST, MACON 31201
HERRON, JAMES G. 61 ACT IM
1102 EAST LAMAR AVE, AMERICUS 31709
HERSH, THEODORE 29 ACT GE
1365 CLIFTON RD NE, ATLANTA 30322
HERSKOWITZ, LOUIS J. 29 ACT D,IM
4555 NORTH SHALLOWFORD RD, ATLANTA 30338
HESTER, JESSE D. 66 ACT OBG
PO BOX 1608, TIFTON 31793
HESTER, T. RODERICK, JR. 29 ACT PS
1365 CLIFTON RD NE, ATLANTA 30322
HETHERINGTON, THOMAS A. 11 ACT R
311 EAST HALL ST, SAVANNAH 31401
HEWELL, GUY C. 29 ACT OBG
1123 BERKSHIRE RD NE, ATLANTA 30306
HICKS, JOHN W., JR. 17 ACT GS
1902 LELAND DR, MARIETTA 30067
HICKS, L.G., JR. 33 ACT AN
MADISON ST, CLARKESVILLE 30523
HICKS, W.L., JR. 30 ACT EM
PO BOX 1956, BRUNSWICK 31521
HIGHTOWER, JOHN A. 30 ACT IM
MARSHVIEW CIRCLE DR, BRUNSWICK 31520
HILL, DANIEL T. 70 ACT FP
PO BOX 629, TRENTON 30752
HILL, EUGENE A. 29 ACT OBG
5667 PEACHTREE-DUNWOODY RD, ATLANTA 30342
HILL, J. WAYNE 34 ACT OBG
1100 VINE ST, GAINESVILLE 30501
HILL, JOHN B. 15 ACT OBG
740 PRINCE AVE, ATHENS 30601
HILL, JULIUS N., III 29 ACT AN
353 PARKWAY DR NE, ATLANTA 30312
HILL, MEREDITH L., JR 24 AF US
BOX 187, KINGSLAND 31548
HILL, ROBERT S. 54 ACT GS
1503 WINTER ST, AUGUSTA 30904
HILL, WALTER JAMES 29 A P
1293 PEACHTREE ST NE, ATLANTA 30309
HILL, WILLIAM H. 29 ACT GS
3280 HOWELL MILL RD NW 201, ATLANTA 30327
HILLIARD, KATHARINE A. 29 I&R P
1884 RIDGEWOOD DR NE, ATLANTA 30307
HILLIARD, KATHARINE A. 29 I&R P
1884 RIDGEWOOD DR NE, ATLANTA 30307
HILLIS, CHARLES L. 75 ACT EM,FP
PO BOX 408, JESUP 31545
HILSMAN, J.H. 29 ACT IM
35 COLLIER RD NW, ATLANTA 30309
HILSMAN, THOMAS A. 23 ACT FP
PO BOX 1908, ALBANY 31701
HIMOT, EDWARD D. 17 ACT NEP
833 CAMPBELL HILL ST ' 117, MARIETTA 30060
HINES, ROBERT C. 27 ACT FP
HARBIN CLINIC, ROME 30161
HINKLE, JAMES E. 29 ACT AN
4575 NORTH SHALLOWFORD RD, CHAMBLEE 30342
HINRICHS, MARC B. 68 ACT R
210 BATTLE ST, LA GRANGE 30240
HINSON, WARREN A. 29 ACT P
5064 ROSWELL RD NE, ATLANTA 30342
HINTON, GOLDEN S. 15 ACT OPH
PO BOX 5518, ATHENS 30604
HIROMOTO, JESUS H. 56 ACT NS
2704 NORTH OAK ST BLDG L, VALDOSTA 31602
HIRSCH, JACK 47 ACT IM
909 CENTER ST, COLUMBUS 31901
HIRSCH, ROBERT J. 17 ACT OBG
1230 JOHNSON FERRY RD, MARIETTA 30067
HIRSH, EUGENE H. 29 ACT IM,GE
3280 HOWELL MILL RD STE 103, ATLANTA 30327
HIRT, ALFREDO 29 ACT U
490 PEACHTREE ST NE, ATLANTA 30308
HISSAM, JAMES E. 11 ACT FP
361 COMMERCIAL DR, SAVANNAH 31406
HITCH, WILLIAM S. 11 ACT TS,CD
351 EAST COMMERCIAL DR, SAVANNAH 31406
HIXSON, JACK D. 70 ACT IM,PUD
MEDICAL PLAZA N STE 504, CHATTANOOGA 37403
HO, RAYMOND C. 61 ACT PD
PO BOX 248, AMERICUS 31709
HOAG, JOEL B. 31 ACT ORS
PO BOX 1507, CALHOUN 30701
HOBBS, JOSEPH 54 ACT FP
MEDICAL COLLEGE OF GEORGIA, AUGUSTA 30902
HOBBY, CHARLES F. 56 ACT R
2704-D NORTH OAK ST, VALDOSTA 31602
HOBBY, LOVIC W. 29 ACT PS
35 COLLIER RD NW, ATLANTA 30309
HOBSON, DOUGLAS P. 54 ACT P
MEDICAL COLLEGE OF GEORGIA, AUGUSTA 30912
HOBSON, GERALD J. 17 ACT OPH
623 SOUTH MAIN ST, WOODSTOCK 30188
HODGES, C. HUBERT, JR. 65 ACT U
BOX 1576, THOMASVILLE 31792
HODGES, CHARLES A., JR. 56 ACT AN
PO BOX 1727, VALDOSTA 31602
HODGES, FRED BARRY, III 76 ACT ORS
1103 MEMORIAL DR, DALTON 30720
HODGES, HUGH O. 03 ACT FP
330 HIGHLAND DR, WINDER 30680
HODGES, JOHN M. 17 R GS
335 WHITLOCK AVE SW, MARIETTA 30064
HODGES, MALCOLM R. 06 ACT FP
340 WESLEY CIR, MACON 31204
HOFFA, DANNY E. 42 ACT PTH
FAIRVIEW PARK HOSPITAL, DUBLIN 31021
HOFFMAN, BYRON J. 29 ACT IM
768 JUNIPER ST NE, ATLANTA 30308
HOFFMAN, FRANK 11 ACT OTO
24 MEDICAL ARTS CENTER, SAVANNAH 31405
HOFFMAN, JAMES C., JR. 29 ACT R
1365 CLIFTON RD NE, ATLANTA 30322
HOFFMAN, JOSEPH I., JR. 29 ACT ORS
2945 STONE HOGAN RD CONN SW, ATLANTA 30331
HOGAN, J.T., JR. 06 ACT GS
781 SPRING ST, MACON 31201
HOGUE, WILLIAM L. 54 ACT R
820 ST SEBASTIAN WAY, AUGUSTA 30902
HOLBROOK, WILLIAM H., JR. 15 ACT R
797 COBB ST, ATHENS 30601
HOLDEN, WILLIAM H. 06 ACT US
RR 3 MIDDLETON, NOVA SCOTIA BOS1PO
HOLDER, J.S. 68 ACT GS
303 SMITH ST, LA GRANGE 30240
HOLLADAY, WILLIAM E., JR. 17 ACT IM
787 CAMPBELL HILL ST, MARIETTA 30060
HOLLAND, BERNARD C. 29 ACT P
1711 UPPERGATE DR NE, ATLANTA 30322
HOLLAND, WALLACE E., JR. 11 I&R IM
MEMORIAL MEDICAL CENTER, SAVANNAH 31403
HOLLIS, CHARLES D., JR. 23 ACT IM
1610 NORTH VALENCIA DR, ALBANY 31707
HOLLIS, DAN STEPHEN 47 ACT OPH
ST FRANCIS MEDICAL PARK, COLUMBUS 31904
HOLLOMAN, J.J. 11 ACT GP
313 EAST HALL ST, SAVANNAH 31401
HOLLOWAY, ALFRED M. 69 ACT FP
204 CHEROKEE RD, THOMASTON 30286
HOLLOWAY, CHARLES E. 29 ACT GS
478 PEACHTREE ST NE, ATLANTA 30308
HOLLOWAY, EMORY W., JR. 06 ACT R
294 IDLEWILD RD, MACON 31210
HOLLOWAY, GEORGE A., JR. 29 ACT AN
1968 PEACHTREE RD NW, ATLANTA 30309
HOLLOWAY, JOHN T. 72 ACT GP
1101 CHURCH ST, WAYCROSS 31501
HOLLOWAY, WILMER O. 66 ACT R
PO BOX 388, TIFTON 31794
HOLMAN, C.M. 23 ACT GYN
412 FOURTH AVE, ALBANY 31705
HOLMES, HAMILTON E. 29 ACT ORS
340 BOULEVARD NE, ATLANTA 30312
HOLMES, WILLIAM C. 15 ACT FP
740 PRINCE AVE, ATHENS 30601
HOLT, EDWARD 66 ACT FP
PO BOX 549, ADEL 31620
HOLTZ, NOEL 17 ACT N
522 NORTH AVE, MARIETTA 30060
HOLZMAN, GERALD B. 54 ACT OBG
MEDICAL COLLEGE OF GEORGIA, AUGUSTA 30912
HOMLAR, MARJORIE 29 ACT FP
6500 VERNON WOODS DR ' C-23, ATLANTA 30328
HONARVAR, SAMAD 13 ACT OTO
354 ARCADO RD, LILBURN 30247
HOOD, E.D. 11 ACT FP
241 ABERCORN ST, SAVANNAH 31401
HOOD, HERB L. 23 ACT AN
2335 WINCHESTER DR, ALBANY 31707
HOOD, JONATHAN C. 47 I&R
PO BOX 951, COLUMBUS 31994
HOODA, SUDERSHAN K. 02 ACT IM,CD
511 N COBB ST STE 2, MILLEDGEVILLE 31061
HOOKS, VENDIE H., III 54 ACT CRS
MEDICAL COLLEGE OF GEORGIA, AUGUSTA 30912

HOOPER, DONALD 29 ACT AN
145 15TH ST #1401, ATLANTA 30309
HOOPER, ROBERT J. 06 ACT OPH
645 FIRST ST, MACON 31201
HOOPES, JEFFREY R. 23 ACT CD
PO BOX 1326, ALBANY 31702
HOOSE, KENNETH A., JR. 22 ACT IM
495 WINN WAY 'B-260, DECATUR 30030
HOPE, THOMAS D. 06 ACT N
829 FIRST ST, MACON 31201
HOPKINS, CHARLES T., JR. 29 I&R ORS
80 BUTLER ST, ATLANTA 30303
HOPKINS, L.C., JR. 29 ACT N
1365 CLIFTON RD NE, ATLANTA 30322
HOPKINS, MARK D. 36 S
APT G-16 CASTAWAYS, WARNER ROBINS 31093
HOPKINS, RALPH D. 34 ACT R
743 SPRING ST, GAINESVILLE 30505
HOPKINS, WILLIAM A. 29 R GS
5669 PEACHTREE-DUNWOODY RD, ATLANTA 30342
HORN, EDGAR B. 47 ACT GS
711 CENTER ST STE 224, COLUMBUS 31901
HORN, WARREN B. 15 ACT AN
PO BOX 6294, ATHENS 30604
HORNBACK, WILLIAM L., III 66 ACT ORS
PO BOX 1368, TIFTON 31793
HORNBERGER, R.B. 29 ACT PTH
340 BOULEVARD NE, ATLANTA 30312
HORNE, KENNETH W. 15 ACT R
1010 PRINCE AVE, ATHENS 30601
HORNEY, JOHN T. 29 ACT IM
3250 HOWELL MILL RD NW, ATLANTA 30327
HORSEMAN, ROBERT W. 54 ACT AN
PO BOX 261, EVANS 30809
HORTMAN, H.C. 27 ACT OBG
10 HOSPITAL CIR, ROME 30161
HOSFORO, J. MICHAEL 34 ACT PD
1220 SHERWOOD PARK DR, GAINESVILLE 30501
HOSTETLER, RUSSELL M. 06 I&R FP
784 SPRING ST, MACON 31201
HOTALEN, WILLIAM B. 29 ACT OM
4 WOODLAWN DR, MARIETTA 30067
HOTCHKISS, RICHARD S. 29 I&R IM
6 WHITTIER PL APT 4-C, BOSTON MA 02114
HOTHEM, ARDEN LUTHER 34 ACT PS
1224 SHERWOOD PARK DR NE, GAINESVILLE 30501
HOTZ, JAMES A. 23 ACT IM
1700 EAST BROAD AVE, ALBANY 31705
HOUSE, FREDRICK C. 54 ACT AL,IM
3646 WHEELER RD STE 1-A, AUGUSTA 30909
HOUSE, JOHN C. 03 ACT FP
330 HIGHLAND DR, WINDER 30680
HOUSER, FRANK M. 06 ACT FP
781 SPRING ST, MACON 31201
HOUSER, FRANK M., JR. 29 ACT PD
3280 HOWELL MILL RD, ATLANTA 30327
HOUSTON, G. COURTNEY 19 ACT GS
3004 SECOND ST SE, MOULTRIE 31768
HOUSTON, THOMAS P. 27 ACT FP
302 TURNER MCCALL BLVD, ROME 30161
HOWARD, ALBERT R. 11 ACT AN
8 STEPHENSON AVE, SAVANNAH 31405
HOWARD, CHARLES K. 29 ACT PH
5084 NORTH PEACHTREE RD, ATLANTA 30338
HOWARD, DENNIS R. 06 ACT FP
MERCER UNIV SCHOOL OF MEDICINE, MACON 31207
HOWARD, JAMES A. 29 ACT P
960 JOHNSON FERRY RD NW, ATLANTA 30342
HOWARD, LEE, JR. 11 R PTH
12 EAST 50TH ST, SAVANNAH 31405
HOWARD, LEONARD F. 65 ACT FP
DOCTORS PK, CAIRO 31728
HOWARD, PEGGY J. 72 R OBG
3296 CENTRAL AVE, WAYCROSS 31501
HOWARD, ROBERT M. 11 ACT PTH
622 EAST 44TH ST, SAVANNAH 31405
HOWARD, T.J. 54 ACT IM,GER
2316 WRIGHTSBORO RD, AUGUSTA 30904
HOWELL, BARBARA P. 29 ACT OM
620 PEACHTREE ST NE, ATLANTA 30365
HOWELL, CHARLES G., JR. 54 ACT PDS
1120 15TH ST, AUGUSTA 30912
HOWELL, DOUGLAS E. 16 ACT GS
33 SW UPPER RIVERDALE RD, RIVERDALE 30274
HOWELL, TOM S., JR. 29 ACT GS
620 PEACHTREE ST NE, ATLANTA 30308
HOWELL, WILLIAM HARVEY 04 ACT GP
41 NELSON ST, CARTERSVILLE 30120
HOWINGTON, JERRY W. 54 ACT R
820 ST SEBASTIAN WAY, AUGUSTA 30902
HOWLAND, W. SLOCUM, JR. 29 ACT ORS
3250 HOWELL MILL RD NW, ATLANTA 30327
HOWSE, RALPH M. 27 ACT U
1825 MARTHA BERRY HWY, ROME 30161
HU, HSHI YUNG 15 ACT FP
PO BOX 186, COMER 30629
HUBBARD, CHARLES N. 10 ACT ORS
148 CLINIC AVE, CARROLLTON 30117
HUBBARD, OONALO E. 29 ACT OBG
35 COLLIER RD NW, ATLANTA 30309
HUBBARD, GEORGE B., JR. 47 ACT OPH
2012 10TH AVE, COLUMBUS 31901
HUBBARD, JAMES A. 23 ACT OBG
401-B SOUTH MADISON, ALBANY 31701
HUBBELL, ROBERT W. 22 ACT IM
2193 NORTH DECATUR RD, DECATUR 30033
HUBBUCH, SEBASTIAN O. 47 I&R FP
PO BOX 951, COLUMBUS 31994
HUBER, DOUGLAS C. 32 ACT PTH
DOUGLAS GEN HOSPITAL, DOUGLASVILLE 30134
HUBER, JAMES D. 48 ACT IM
7650 COVINGTON HWY, LITHONIA 30058
HUBER, STEPHEN C. 47 ACT DR
6152 CAPE COD CT, COLUMBUS 31904
HUBERDEAU, RENE MARC 68 ACT ORS
303 SMITH ST, LAGRANGE 30240
HUBRICH, LEON R. 15 ACT ORS
1000 HAWTHORNE AVE, ATHENS 30610
HUCKABY, C. BRUCE 06 ACT GE
836 ORANGE TERR, MACON 31201
HUDGINS, WILLIAM B. 22 ACT IM
500 IRVIN CT STE C-240, DECATUR 30030
HUOSON, CARLTON B. 04 ACT R
15 WOODVIEW DR, CARTERSVILLE 30120
HUDSON, JACK 54 ACT FP
BOX 5787, AUGUSTA 30906
HUDSON, JAMES B. 54 ACT IM
TALMADGE MEMORIAL HOSPITAL, AUGUSTA 30912
HUDSON, JOHN ALAN 06 ACT IM
784 SPRING ST, MACON 31201
HUDSON, RONALD M. 47 ACT FP
2100 NORTH AVENUE, COLUMBUS 31904
HUDSON, WALTER LLOYD 47 ACT PD
2039 WARM SPRINGS RD, COLUMBUS 31904
HUDSON, WILLIAM H. 54 ACT ORS
820 ST SEBASTIAN WAY, AUGUSTA 30910
HUFF, GAREY H. 03 ACT FP
206 CANDLER ST, WINDER 30680
HUFF, PRENTIS B. 22 ACT ORS
755 COLUMBIA DR STE 825, DECATUR 30030
HUFF, THOMAS A. 54 ACT END
MEDICAL COLLEGE OF GEORGIA, AUGUSTA 30912
HUFFMAN, GALEN C. 11 ACT P
PO BOX 13607, SAVANNAH 31406
HUG, CARL C., JR. 29 ACT AN
1364 CLIFTON RD NE, ATLANTA 30322
HUGER, WILLIAM, JR. 29 ACT PS
35 COLLIER RD NW, ATLANTA 30309
HUGHES, JOE L. 29 ACT ORS
1311 CLEVELAND AVE, EAST POINT 30344
HUGHES, JOHN L. 54 ACT P
2058 CENTRAL AVE, AUGUSTA 30904
HUGHES, RONALD M. 66 ACT OPH
PO BOX 986, TIFTON 31794
HUGHSTON, JACK C. 47 ACT ORS
6262 HAMILTON RD, COLUMBUS 31904
HUGULEY, CHARLES M., JR. 29 ACT IM
1365 CLIFTON RD NE, ATLANTA 30322
HUIE, LYNN M. 71 ACT FP
120 WEST HIGHLAND AVE, MONROE 30655
HUIE, RALPH A., JR. 29 ACT IM
3415 ASHWOOD LN, CHAMBLEE 30341
HULL, OAVID S. 54 ACT OPH
MEDICAL COLLEGE OF GEORGIA, AUGUSTA 30912
HULL, JAMES D., III 32 ACT GS
8954 HOSPITAL DR ' 105C, DOUGLASVILLE 30134
HULSE, EDWIN T. 70 ACT OPH
1 THOMAS RD, FT OGLETHORPE 30742
HUMPHREYS, JOHN L. 29 ACT OPH
615 PEACHTREE ST NE, ATLANTA 30308
HUMPHRIES, ARTHUR L., JR. 54 ACT GS
TALMADGE MEMORIAL HOSPITAL, AUGUSTA 30912
HUMPHRIES, CHARLIE, JR. 23 ACT OBG
401-B SOUTH MADISON ST, ALBANY 31701
HUMPHRIES, WILLIAM C. 30 R GS
13 TANGLEWOOD RD, ST SIMONS IS 31522
HUNG, LARRY H.Y. 47 ACT PTH
BOX 4176, COLUMBUS 31904
HUNT, JACK R. 47 ACT IM
1005 TALBOTTON RD, COLUMBUS 31995
HUNT, JAMES 13 ACT FP
PO BOX 398, DULUTH 30136
HUNT, JESSE L. 30 ACT FP
PO BOX 1956, BRUNSWICK 31521
HUNT, JOHN B. 56 ACT U
401 WOODROW WILSON DR, VALDOSTA 31602
HUNT, JOHN H. 11 ACT PTH
PO BOX 23089, SAVANNAH 31403
HUNT, LOREN W., JR. 15 ACT IM,PUD
1010 PRINCE AVE, ATHENS 30606
HUNT, THOMAS JEFFERSON 59 ACT GS
610 SOUTH EIGHTH ST, GRIFFIN 30223
HUNTER, CONWAY W., JR. 29 ACT OBG
4555 NORTH SHALLOWFORD RD, ATLANTA 30338
HUNTER, LETHA Y. 29 ACT ORS
105 COLLIER RD NW STE 5000, ATLANTA 30367
HUNTER, STEPHEN C. 47 ACT ORS
6262 HAMILTON RD, COLUMBUS 31904
HUPMAN, AARON J. 29 ACT D
354 ARCADO RD STE 2, LILBURN 30247
HURD, RICHARD A., JR. 29 ACT ORS
4536 CHAMBLEE-DUNWOODY RD NE, ATLANTA 30338
HURST, J. WILLIS 29 ACT IM
69 BUTLER ST SE, ATLANTA 30303
HURST, JAMES B. 02 ACT PTH
BALDWIN CO HOSPITAL, MILLEDGEVILLE 31061
HURT, MARION W. 74 R FP
512 WASHINGTON AVE, SANDERSVILLE 31082
HURTEAU, JOHN E. 15 ACT PS
1010 PRINCE AVE, ATHENS 30606
HUTCHESON, MORRIS W. 11 ACT PD
5102 PAULSEN ST, SAVANNAH 31405
HUTCHINGS, WILLIAM S., II 06 I&R FP
784 SPRING ST, MACON 31208
HUTCHINSON, CHARLES L. 17 ACT PD
4001 CANTON HWY STE 6, MARIETTA 30066
HUTCHINSON, J.R.B. 29 ACT OTO,A
1462 MONTREAL RD STE 403, TUCKER 30084
HUTCHINSON, WILLIAM L., JR. 22 ACT OBG
5040 SNAPFINGER WOODS DR, DECATUR 30035
HUTCHISON, NORTON H. 70 R FP
RTE 3 FAIRFIELD PK, SHELBYVILLE TN 37160
HUTTENBACH, DIRK E. 17 ACT P
STE 440, MARIETTA 30090
HUTTO, MARK C. 29 ACT P
2150 PEACHFORD RD STE B, ATLANTA 30338
HWANG, STEVE K. 16 ACT GS
PO BOX 590, RIVERDALE 30274

HYDEN, WILLIAM U. 27 ACT GP
SIMMONS ST #11, TRION 30753
HYDRICK, JOHN T. 13 ACT OBG
3400 MCCLURE BRIDGE RD, DULUTH 30136
HYORICK, PETER 29 ACT OBG
1100 CLEVELAND AVE 201, EAST POINT 30344
HYERS, JOHN J. 29 ACT AN
35 COLLIER RD NW STE 560, ATLANTA 30309

I

IHNEN, MENARD 54 ACT PTH
1350 WALTON WAY (10), AUGUSTA 30910
IMHOFF, JOHN E. 30 I&R OPH
3215 SHRINE RD, BRUNSWICK 31520
IMHOFF, LYNNE H. 30 I&R AN
3215 SHRINE RD, BRUNSWICK 31520
INGLIS, E.P., JR. 17 ACT GP
50 PLAZA WAY STE B, MARIETTA 30060
INGRAM, CHARLES T. 22 ACT AN
2673 SHETLAND DR, DECATUR 30033
INMAN, JOHN S., JR. 23 ACT OBG
414 FIFTH AVE, ALBANY 31701
INMAN, WILLIAM O., JR. 30 ACT FP
2700 PARKWOOD DR, BRUNSWICK 31523
INNES, BRUCE J. 06 ACT CD,TS
856 FIRST ST, MACON 31201
INSIGNARES, MANUEL S. 48 ACT AN
2578 HARVEST DR, CONYERS 30208
ISAACSON, IRA 29 ACT AN
1364 CLIFTON RD NE, ATLANTA 30322
ISAACSON, RONALO 11 ACT GS
5102 PAULSEN ST STE 2, SAVANNAH 31405
ISELE, ANTHONY F. 23 ACT PTH
PO BOX 1908, ALBANY 31703
ISENBERG, SIDNEY 29 ACT P
44 25TH ST NW, ATLANTA 30309
ISKANDER, KARIM 70 ACT OBG
PO BOX 578, ROSSVILLE 30741
ISLEY, ROBERT A. 13 ACT PD
2121 FOUNTAIN DR, SNELLVILLE 30278
ISRAEL, PHILIP Z. 17 ACT GS
833 CAMPBELL HILL ST ' 240, MARIETTA 30090
ISSHAK, GEORGE 48 ACT GS
1359 MILSTEAD RD STE 202, CONYERS 30207
IVEY, C. RAY, JR. 36 ACT FP
1554 WATSON BLVD, WARNER ROBINS 31093
IVEY, JOHN C. 29 ACT GS
PO BOX 399, MEANSVILLE 30256

J

JABLOW, MITCHELL A. 17 ACT FP
2550 WINDY HILL RD STE 307, MARIETTA 30067
JACKSON, BILLY JOE 34 ACT AN
743 SPRING ST, GAINESVILLE 30505
JACKSON, EUGENE H. 19 ACT FP
PO BOX 2307, MOULTRIE 31768
JACKSON, GORDON W. 06 ACT OBG
380 HOSPITAL DR, MACON 31201
JACKSON, HENRY C. 45 ACT FP
PO BOX 308, MANCHESTER 31816
JACKSON, JAMES W. 11 ACT GS
1 MEDICAL ARTS CENTER, SAVANNAH 31405
JACKSON, JOSEPH L. 09 ACT FP
PO BOX 230, WAYNESBORO 30830
JACKSON, JOSEPH M. 24 ACT FP
BOX 578, FOLKSTON 31537
JACKSON, ROBERT W., DOS 65 AF GS
PO BOX 1696, THOMASVILLE 31792
JACKSON, THOMAS W. 27 ACT OBG
320 WEST NINTH ST, ROME 30161
JACKSON, ZACH W. 29 ACT OPH
2911 PHARR CT S #906, ATLANTA 30305
JACOBS, CECIL F. 66 ACT EM
PO BOX 90, PORTAL 30450
JACOBS, IVEY 72 ACT OTO
PO BOX 882, WAYCROSS 31501
JACOBS, JOHN L. 29 ACT A
2883 ANDREWS DR NW, ATLANTA 30305
JACOBS, JULIAN 29 S IM
1670 CLAIRMONT RD, DECATUR 30033
JACOBS, L. DAVIS 72 ACT FP
PO BOX 156, WAYCROSS 31501
JACOBS, LOUIS JERRY 02 ACT P
169 ADMIRALTY WAY NW, MILLEDGEVILLE 31061
JACOBS, NORMAN FREDERICK, JR. 22 ACT IM,ID
2712 NORTH DECATUR RD, DECATUR 30033
JACOBSON, ALAN I. 17 ACT PTH
PO BOX 665, MABLETON 30059
JACOBSON, DAVID J. 29 ACT OBG
993 JOHNSON FERRY RD NE, ATLANTA 30342
JAEGER-LEE, DOROTHY S. 29 R PD,CHP
3458 ROXBORO RD NE, ATLANTA 30326
JAFFE, STEVEN L. 29 ACT P,CHP
6667 VERNON WOODS DR NE, ATLANTA 30328
JAMES, C.W., JR. 06 ACT GP
3741 HOUSTON AVE, MACON 31201
JAMES, FLOYD 76 ACT PTH
PO BOX 1168, DALTON 30720
JAMES, JACK DONALD 71 ACT OBG
333 ALCOVA ST, MONROE 30655
JAMES, LILLAS L. 06 ACT GP
745 PINE ST, MACON 31201
JAMES, W. SCOTT 29 ACT PD
993-D JOHNSON FERRY RD NE, ATLANTA 30342
JANKO, GARY S. 29 ACT
5667 PEACHTREE DUNWOODY RD, ATLANTA 30342
JANN, WILLIAM K., JR. 22 ACT PD
1901 CENTURY BLVD STE 20, ATLANTA 30345
JANTER, THOMAS B. 22 ACT PD
4536 CHAMBLEE-DUNWOODY RD, ATLANTA 30338
JARDINA, PHILIP M. 22 ACT IM
711 CHURCH ST, DECATUR 30030
JARMAN, JULIAN A. 29 S GS
1670 CLAIRMONT RD, DECATUR 30033
JARRARO, GEORGE T. 20 ACT IM
PO BOX 609, NEWNAN 30263
JARRATT, W.D. 06 ACT OPH
PO BOX 956, MACON 31202
JARRELL, FLOYO C., JR. 47 ACT OTO
PO BOX 4276, COLUMBUS 31995
JARRELL, HAROLD G. 47 ACT OBG
629 20TH ST, COLUMBUS 31904
JARRELL, ROBERT J. 10 ACT R
605 DIXIE ST, CARROLLTON 30117
JARRETT, EUGENE C., III 65 ACT PD
SOUTHWESTERN STATE HOSP, THOMASVILLE 31792
JARRETT, WILLIAM H. 29 ACT OPH
2004 PEACHTREE RD NW, ATLANTA 30309
JARVIS, JACK R. 29 S P
1670 CLAIRMONT RD, DECATUR 30333
JAY, M. SUSAN 54 ACT PD
MEDICAL COLLEGE OF GEORGIA, AUGUSTA 30910
JAY, WALTER M. 54 ACT OPH
MEDICAL COLLEGE OF GEORGIA, AUGUSTA 30912
JAYARAJ, HARIYEBBE C. 36 ACT IM
1043 NORTH HOUSTON RD, WARNER ROBINS 31093
JEANS, PARK C., JR. 54 ACT OPH
1021-15TH ST STE 5, AUGUSTA 30901
JELKS, LOUIS R. 57 ACT GS
PO BOX 128, REIDSVILLE 30453
JENKINS, CHARLES A. 26 ACT IM
PO BOX 395, VIENNA 31092
JENKINS, MORRIS L. 31 ACT FP
BOX 125, CALHOUN 30701
JENKINS, W. THOMAS 34 ACT OBG
1211 SHERWOOD PARK DR, GAINESVILLE 30501
JENKINS, W.F. 47 ACT R
1580 DIXON DR, COLUMBUS 31906
JENNINGS, C.M. 17 ACT IM
641 CHURCH ST, MARIETTA 30060
JENNINGS, E.R. 30 ACT GS
2514 WREN ST, BRUNSWICK 31520
JENNINGS, HENRY S., JR. 34 ACT IM
710 BROAD ST SE, GAINESVILLE 30501
JENNINGS, JANE B. 11 ACT PTH,BLB
PO BOX 23103, SAVANNAH 31403
JENNINGS, ROBERT E. 58 ACT FP
ARLINGTON CITY HOSPITAL, ARLINGTON 31713
JENNINGS, W.D., JR. 54 ACT GS
VA HOSPITAL, AUGUSTA 30904
JERKINS, GREGORY LEE 29 I&R
300 BOULEVARD NE, ATLANTA 30312
JOEL, CHARLES, JR. 29 S N
4540 RUNNEMEDE RD NW, ATLANTA 30327
JOFFE, ALAN L. 29 ACT OBG
1175 PEACHTREE ST NE, ATLANTA 30361
JOHN, FARES 54 ACT PTH
MEDICAL COLLEGE OF GEORGIA, AUGUSTA 30904
JOHNS, CHARLES W. 06 ACT FP
770 PINE ST STE 510, MACON 31206
JOHNS, R. ALLEN, II 29 ACT AN
35 COLLIER RD NE STE 560, ATLANTA 30309
JOHNSON, A.M. 56 ACT PD
1612 NORTH OAK ST, VALDOSTA 31601
JOHNSON, ALLYN C., JR. 34 ACT IM
1144 VINE ST NE, GAINESVILLE 30501
JOHNSON, C.D. 47 ACT FP
2121 WARM SPRINGS RD, COLUMBUS 31904
JOHNSON, C.E., JR. 06 ACT ORS
870 HIGH ST, MACON 31204
JOHNSON, C.F., JR. 54 ACT AN
8 WHITE OAK DR, NORTH AUGUSTA SC 29841
JOHNSON, C.M. 30 ACT P
PO BOX 1830, ST SIMONS IS 31522
JOHNSON, CHARLES E. 29 ACT IM
3250 HOWELL MILL RD NE, ATLANTA 30327
JOHNSON, CHARLES G. 16 ACT FP
217 MEDICAL WAY, RIVERDALE 30274
JOHNSON, EDWARD L. 22 ACT ORS
2910 NORTH DRUID HILLS RD, ATLANTA 30329
JOHNSON, G. HUGO, JR. 11 ACT GP
116 EAST OGLETHORPE AVE, SAVANNAH 31401
JOHNSON, GEORGE C. 34 ACT P
660-C LANIER PARK DR, GAINESVILLE 30505
JOHNSON, GRADY H. 42 ACT FP
112 ROWE ST, DUBLIN 31021
JOHNSON, HENRY C., JR. 29 ACT R
35 COLLIER RD NW, ATLANTA 30309
JOHNSON, JANET K. 54 ACT PD,EM
1350 WALTON WAY, AUGUSTA 30904
JOHNSON, JIMPSEY B. 54 ACT R
820 ST SEBASTIAN WAY STE 1-A, AUGUSTA 30902
JOHNSON, JOE H. 06 I&R GS
MEDICAL CENTER OF CENTRAL GA, MACON 31210
JOHNSON, JULIUS T. 54 ACT P
820 ST SEBASTIAN WAY STE 3-B, AUGUSTA 30902
JOHNSON, L. MALCOLM 29 ACT OM
3580 ATLANTA AVE, HAPEVILLE 30354
JOHNSON, LEWIS D. 22 ACT IM
4303 LAVISTA RD, TUCKER 30084
JOHNSON, MARTIN L. 10 ACT GP
PO BOX 490, BOWDON 30108
JOHNSON, MARY M. 29 ACT NS
5675 PEACHTREE-DUNWOODY RD, ATLANTA 30342
JOHNSON, MCCLAREN 29 ACT GE
5594 CORONATION CT NE, ATLANTA 30338
JOHNSON, MILTON I., JR. 06 ACT FP
2605 CHEROKEE AVE, MACON 31204
JOHNSON, NEAL D. 47 I&R FP
7325 KIRKWOOD DR, COLUMBUS 31904
JOHNSON, OTTO B., JR. 42 ACT IM
606 ACADEMY AVE, DUBLIN 31021
JOHNSON, R. JULIAN 29 ACT IM
5667 PEACHTREE DUNWOODY RD, ATLANTA 30342

JOHNSON, RAY E. 54 ACT CD
820 ST SEBASTIAN WAY, AUGUSTA 30902
JOHNSON, RAY L. 29 ACT P
478 PEACHTREE ST STE 909-A, ATLANTA 30308
JOHNSON, RICHARD H. 29 ACT IM
2045 PEACHTREE RD NE, ATLANTA 30309
JOHNSON, ROBERT H., JR. 54 ACT GS
MEDICAL COLLEGE OF GEORGIA, AUGUSTA 30912
JOHNSON, ROBERT W. 54 ACT GS
820 ST SEBASTIAN WAY STE 7-C, AUGUSTA 30902
JOHNSON, ROY J., JR. 05 ACT FP
RTE 4 BOX 385, FITZGERALD 31750
JOHNSON, STEVEN D. 29 ACT IM,EM
339 ELMIRA PL, ATLANTA 30307
JOHNSON, THOMAS D. 23 ACT IM
PO BOX 288, ALBANY 31702
JOHNSON, WALTER E., JR. 54 ACT AN
BOX 3403 HILL STATION, AUGUSTA 30904
JOHNSTON, BENJAMIN M. 06 ACT IM
800 FIRST ST STE 310, MACON 31201
JOHNSTON, G.A. 06 ACT FP
800 FIRST ST STE 310, MACON 31201
JOHNSTON, JACK H. 17 ACT IM
86 SOUTH COBB DR, MARIETTA 30063
JOHNSTON, JANICE W. 29 ACT OBG
1938 PEACHTREE RD STE 101, ATLANTA 30309
JOHNSTON, JOSEPH F. 54 ACT AN
MEDICAL COLLEGE OF GEORGIA, AUGUSTA 30912
JOINER, HARTWELL 34 ACT IM
319 NORTH BRADFORD ST, GAINESVILLE 30501
JOINER, JAMES C., III 22 ACT OPH
487 WINN WAY STE 201, DECATUR 30030
JOINER, R.M. 19 ACT PD
1317 SOUTH MAIN, MOULTRIE 31768
JOLLEY, FLEMING L. 30 ACT NS
BOX 205, SEA ISLAND 31561
JONES, ARTHUR B., JR. 29 ACT OBG
384 PEACHTREE ST NE, ATLANTA 30308
JONES, CARL C., JR. 29 ACT A
3316 PIEDMONT RD, ATLANTA 30305
JONES, CHARLES L. 34 ACT PD
274 ENOTA DR NE, GAINESVILLE 30505
JONES, E. LADD, JR. 29 ACT ORS
3250 HOWELL MILL RD NW, ATLANTA 30327
JONES, ELLIS L. 29 ACT TS
1365 CLIFTON RD NE, ATLANTA 30322
JONES, FOREST D. 22 ACT PD
1901 CENTURY BLVD STE 20, ATLANTA 30345
JONES, FRANK R. 47 I&R
113 SIGERFOOS RD, FT BENNING 31905
JONES, G. FRANK, JR. 54 ACT GS
1503 WINTER ST, AUGUSTA 30904
JONES, GEORGE R. 22 ACT FP
1462 MONTREAL RD STE 318, TUCKER 30084
JONES, GEORGE R. 06 ACT OPH
PO BOX 956, MACON 31202
JONES, GEORGE W., JR. 29 ACT IM
490 PEACHTREE ST NE, ATLANTA 30308
JONES, HENRY B., JR. 06 ACT FP
WEST CLINTON ST, GRAY 31032
JONES, HURLEY D., JR. 30 ACT IM
4036 RIVERSIDE DR, BRUNSWICK 31520
JONES, J. SHERWOOD 76 ACT IM
1209 MEMORIAL DR, DALTON 30720
JONES, JAMES YOUNG 42 ACT OPH
BELLEVUE RD, DUBLIN 31021
JONES, JOHN P. 06 ACT PD
2009 VINEVILLE AVE, MACON 31204
JONES, JONSEY J. 22 I&R AN
4005 GRANTLAND DR, TUCKER 30084
JONES, KENNETH D. 54 ACT P
2058 CENTRAL AVE, AUGUSTA 30904
JONES, LEWIS E. 29 R IM
1752 MORRIS LANDERS DR NE, ATLANTA 30345
JONES, MARY B. 18 ACT FP
3 ATLANTA AVE, HICHOLLS 31554
JONES, NORMAN E. 29 ACT TR
1968 PEACHTREE RD NW, ATLANTA 30309
JONES, PHILIP F. 06 ACT PTH
PO BOX 6000, MACON 31201
JONES, RICHARD B. 29 ACT IM
6500 VERNON WOODS DR NE, ATLANTA 30328
JONES, ROBERT H. 06 ACT IM
675 NEW ST, MACON 31201
JONES, ROGER C. 70 ACT IM
150 CROSS CRESCENT, FORT OGLETHORPE 30742
JONES, RUDOLPH W., JR. 06 ACT IM
883 PINE ST, MACON 31201
JONES, THOMAS C. 06 ACT END,IM
4907 FORSYTH RD, MACON 31210
JONES, WILLIAM B. 34 ACT U
660-G LANIER PARK DR NE, GAINESVILLE 30501
JONES, WILLIAM T. 34 ACT GP
404 GREEN ST NE, GAINESVILLE 30501
JORDAN, CARL R. 11 ACT GS
PO BOX 3567, SAVANNAH 31404
JORDAN, JOSEPH L. 23 ACT FP
504 COLLEGE DR, ALBANY 31705
JORDAN, STEPHEN M. 08 ACT IM
356 NORTHSIDE DR E, STATESBORO 30458
JORDAN, TOMMY H. 34 ACT P
664 LANIER PARK DR NE, GAINESVILLE 30505
JORDAN, W. DAN 29 ACT GS
35 COLLIER RD NW, ATLANTA 30309
JORDAN, WILLIAM K. 06 ACT OBG
675 NEW ST, MACON 31201
JORDAN, WILLIS P., III 27 ACT OBG
10 HOSPITAL CIR, ROME 30161
JOSEPH, ALFRED 29 ACT PD
777 CLEVELAND AVE SW, ATLANTA 30315
JOSEPH, FRANK R. 29 ACT HS
3280 HOWELL MILL RD NW, ATLANTA 30327
JOSEPHS, ALVIN D. 29 R IM
1670 CLAIRMONT RD, DECATUR 30033
JOSEY, JOHN S. 30 ACT OPH
3010 HAMPTON AVE, BRUNSWICK 31520
JOSEY, WILLIAM E. 29 ACT OBG
1365 CLIFTON RD NE, ATLANTA 30322
JOSHI, Y.K. 17 ACT OBG
1001 THORNTON RD 3L5, LITHIA SPRINGS 30057
JOVE, DONNA F. 29 ACT PTH
1216 ARBOR VISTA DR NE, ATLANTA 30329
JOVE, JULIO 22 ACT ORS
487 WINN WAY STE 108, DECATUR 30030
JOWERS, J.R. 54 ACT FP
210 OAK ST, MARTINEZ 30907
JUDY, JAMES C. 11 ACT U
PO BOX 14459, SAVANNAH 31406
JUN, CHANNING S. 50 ACT GS
PO BOX 529, EASTMAN 31023
JUNG, HAEJA K. 16 ACT AL
251 MEDICAL WAY STE B, RIVERDALE 30274
JUNG, HEE C. 16 ACT AN
1262 WICKER CT, RIVERDALE 30296
JURGENSEN, PAUL F. 11 ACT IM
PO BOX 15238, SAVANNAH 31416
JURKIEWICZ, MAURICE J. 29 ACT PS
1365 CLIFTON RD NE, ATLANTA 30322

K

KADIS, GERALD N. 65 ACT NS
704 SOUTH BROAD ST, THOMASVILLE 31792
KAHLE, DAN BRUCE 29 ACT OBG
960 JOHNSON FERRY RD NE, ATLANTA 30342
KAHN, ERIC M. 29 ACT CDS
993-F JOHNSON FERRY RD NE, ATLANTA 30342
KAHN, S. DAVID 29 ACT P
3400 PEACHTREE RD NE, ATLANTA 30326
KAISER, RICHARD R. 17 ACT PD
3001 SOUTH COBB DR SE, SMYRNA 30080
KALATHOOR, J.R. 57 ACT AN
PO BOX 1303, VIDALIA 30474
KALATHOOR, PARANDHAMA R. 57 ACT U
PO BOX 1303, VIDALIA 30474
KALLI, RAMANA V.B. 06 ACT IM,CD
770 PINE ST STE 460, MACON 31201
KANAVAGE, CHESTER B. 01 ACT GS
PO BOX 860, BAXLEY 31513
KANN, HERBERT E., JR. 22 ACT IM
500 IRVIN CT STE C-220, DECATUR 30030
KANTER, W.W. 11 ACT GP
PO BOX 9621, SAVANNAH 31402
KANTO, WILLIAM P., JR. 54 ACT PD
MEDICAL COLLEGE OF GEORGIA, AUGUSTA 30912
KAPLAN, HAROLD JACK 06 I&R FP
784 SPRING ST, MACON 31201
KAPLAN, HENRY J. 22 ACT OPH
1365 CLIFTON RD NE, ATLANTA 30322
KAPLAN, RONALD I. 29 ACT GS
2550 WINDY HILL RD STE 202, MARIETTA 30067
KARASU, SUAT 29 ACT AN
4845 JETT RD NW, ATLANTA 30327
KARASU, ZEYNEP 17 ACT PD
211 CHICOPEE DR, MARIETTA 30060
KARP, HERBERT R. 29 ACT N
1817 CLIFTON RD NE, ATLANTA 30029
KARPAS, ANTHONY E. 29 ACT END
478 PEACHTREE ST NE, ATLANTA 30308
KARSH, RICHARD B. 65 ACT R,PDC
113 WEST HANSEL ST, THOMASVILLE 31792
KARSTEN, MIKELL B. 66 ACT GS
PO BOX 929, TIFTON 31794
KASHLAN, MALAKA AL-AZEM 16 ACT AN
409 ARROWHEAD BLVD BLDG A, JONESBORO 30236
KASSAM, GULZAR B. 29 ACT OBG
478 PEACHTREE ST NE, ATLANTA 30308
KASSAM, SHIRAZ H. 48 ACT OBG
1309 MILSTEAD RD, CONYERS 30207
KATZ, DAVID S. 54 ACT GP,OM
3109 NATALIE CIR, AUGUSTA 30909
KATZ, MYRON M. 16 ACT OBG
259 ARROWHEAD BLVD, JONESBORO 30236
KAUFMAN, NATHAN 54 ACT OS
1003 CHAFEE AVENUE, AUGUSTA 30904
KAUFMANN, GARY E. 29 ACT NS
2550 WINDY HILL RD STE 110, MARIETTA 30067
KAUFMANN, JAMES A. 29 ACT IM
565 WEST PEACHTREE ST NE, ATLANTA 30308
KAVELMAN, DOUGLAS A. 53 ACT IM
PO BOX 687, LUMPKIN 31815
KAVURI, SURENDRANATH 42 ACT PD
112 ROWE ST, DUBLIN 31021
KAY, FERDINAND V. 06 ACT FP
1221 NEWBERG AVE, MACON 31206
KAY, JAMES B., JR. 54 ACT U
1021 15TH ST, AUGUSTA 30901
KEEHAN, JAMES E. 06 ACT OM
2800 WEAVER RD, MACON 31202
KEENE, WILLIS R. 24 ACT IM
1001 NORTH THIRD ST, FOLKSTON 31537
KEENER, ELLIS B. 34 ACT NS
434 ACADEMY ST NE, GAINESVILLE 30501
KEETON, WILLIAM F. 22 ACT AN
755 COLUMBIA DR STE 413, DECATUR 30030
KEITH, THOMAS L. 34 ACT AN
743 SPRING ST, GAINESVILLE 30505
KELLEHER, ROBERT M. 29 ACT D
4536 CHAMBLEE DUNWOODY RD, ATLANTA 30338
KELLER, A. PAUL, JR. 15 ACT OT,OPH
1010 PRINCE AVE, ATHENS 30606
KELLER, ALEXANDER P. 15 ACT OPH
1010 PRINCE AVE, ATHENS 30606
KELLER, JAMES W. 29 ACT ON
1365 CLIFTON RD NE, ATLANTA 30322
KELLER, JOHN A. 16 ACT FP
100 NORTH PARK DR, FAYETTEVILLE 30214

KELLEY, CHARLES N. 34 ACT IM
710 BROAD ST, GAINESVILLE 30501
KELLEY, J. WELOON 59 ACT GS
602 SOUTH EIGHTH ST, GRIFFIN 30223
KELLEY, JAMES M. 27 ACT ORS
310 WEST TENTH ST, ROME 30161
KELLEY, JOHN WALTER 54 ACT CDS
820 ST SEBASTIAN WAY STE 6-A, AUGUSTA 30902
KELLEY, ROBERT E., JR. 15 ACT OBG
740 PRINCE AVE, ATHENS 30601
KELLEY, TERRY V. 06 I&R
MEDICAL CENTER OF CENTRAL GA, MACON 31208
KELLY, ELMO C., III 06 ACT D
380 HOSPITAL DR STE 300, MACON 31201
KELLY, FRANCIS B. 06 ACT ORS
770 PINE ST STE 400, MACON 31201
KELLY, GENE M. 06 ACT AN
148 TEN KNOLLS DR, MACON 31204
KELLY, JAMES O. 29 R GS
3113 LENOX RD, ATLANTA 30324
KELLY, JULIAN O., JR. 11 ACT ORS
601 EAST 66TH ST, SAVANNAH 31405
KELLY, ROBERT O. 54 ST
MEDICAL COLLEGE OF GEORGIA, AUGUSTA 30912
KELLY, WILLIAM D. 11 ACT PTH
11705 MERCY BLVD, SAVANNAH 31406
KELMAN, LESLIE 29 ACT N
993-F JOHNSON FERRY RD NE, ATLANTA 30342
KEMBLE, JOHN W. 02 R N
704 RUNNYMEDE CIR, VIRGINIA BEACH VA 23452
KEMPER, CLIFTON G. 29 ACT FP
956 STOVALL BLVD NE, ATLANTA 30319
KENNEOY, T. EUGENE 13 ACT FP
5424 LITTLE MILL RD, BUFORD 30518
KENNERLY, R. MICHAEL 11 ACT CDS
5400 SUTLIVE ST STE 1, SAVANNAH 31405
KENNY, WILLIAM R. 29 ACT PUD
1968 PEACHTREE ROAD, ATLANTA 30309
KENT, WILLIAM F. 08 ACT OBG
PO BOX 1066, STATESBORO 30458
KENT, WILLIAM R. 55 ACT FP
PO BOX 218, SYLVANIA 30467
KERINS, CRAIG T. 54 ACT ORS
1521 ANTHONY RD, AUGUSTA 30910
KERLEY, CLIFFORD M. 22 ACT R
755 COLUMBIA DR STE 205, DECATUR 30030
KERR, WILLIAM K. 22 R FP
1555 SOUTH JOHNSON FERRY RD, ATLANTA 30319
KESSINGER, JOHN M. 06 ACT CD,TS
770 PINE ST STE 300, MACON 31201
KESSLER, MICHAEL B. 13 ACT EM
970 CLEMENSTONE DR, ATLANTA 30342
KHOURI, JOSEPH 17 ACT IM
2491 PACES FERRY RD, SMYRNA 30080
KIAS, THOMAS N., JR. 15 ACT IM
1010 PRINCE AVE, ATHENS 30601
KIBLER, JAMES A. 42 ACT P
309 BELLEVUE, DUBLIN 31021
KIBLER, ROBERT F. 29 ACT IM
1365 CLIFTON RD NE, ATLANTA 30322
KILARI, SWAMY 72 ACT IM,CD
1921 ALICE ST STE 3-B, WAYCROSS 31501
KILEY, JAMES D. 29 ACT IM
3250 HOWELL MILL RD NE, ATLANTA 30327
KILLEBREW, JAMES G., JR. 68 ACT ORS
303 SMITH ST, LA GRANGE 30240
KILPATRICK, WILLIAM H. 29 ACT OBG
1311 CLEVELAND AVE, EAST POINT 30344
KILPATRICK, ZACHARY M. 54 ACT GE
820 ST SEBASTIAN WAY STE 2-C, AUGUSTA 30902
KIM, CHANG 25 ACT R
PO BOX 783, SWAINSBORO 30401
KIM, H. HAHK 29 ACT PDS
315 BOULEVARD NE STE 332, ATLANTA 30312
KIM, JONG-IN 29 ACT AN
2760-B FELTON DR, EAST POINT 30344
KIM, PIL KWAN 16 ACT AN
8406 CREEKRIDGE CIR, RIVERDALE 30296
KIM, SOO-IL 16 ACT IM
1019 ASTOR AVE, FOREST PARK 30050
KIM, SOON OK 42 ACT OBG
107 VERNON ST, DUBLIN 31021
KIM, SUN-HEE 29 ACT GS
2351 BOLTON RD NW, ATLANTA 30318
KIM, TAE W. 23 ACT EM
1906 COVEY RD, ALBANY 31707
KIMMERLING, RICHARD W. 17 ACT GS
4760 AUSTELL RD, AUSTELL 30001
KINARD, GARLAND E. 70 ACT FP
118 HOWARD ST, ROSSVILLE 30741
KING, CHARLES R. 30 ACT ORS
3204 SHRINE RD, BRUNSWICK 31523
KING, CHARLES RICHARD 19 ACT OBG
3011 FOURTH ST SE, MOULTRIE 31768
KING, GEORGE C. 60 ACT FP
BOX 1209, CLAYTON 30525
KING, J. DUOLEY 29 ACT R
35 LINDEN AVE NE, ATLANTA 30365
KING, J. LON, JR. 06 ACT OBG
380 HOSPITAL DR, MACON 31201
KING, JAMES T. 29 ACT OTO
1890 WEST PACES FERRY RD, ATLANTA 30327
KING, JOHN LAMAR 59 ACT U
653 SOUTH EIGHTH ST, GRIFFIN 30223
KING, JOHN T., JR. 65 ACT OPH
PO BOX 1919, THOMASVILLE 31792
KING, OLIVER W. 17 ACT GS
3001 SOUTH COBB DR SE, SMYRNA 30080
KING, RICHARD 29 ACT TS
35 COLLIER RD NW, ATLANTA 30309
KING, SPENCER B., III 29 ACT CD
EMORY UNIVERSITY CLINIC, ATLANTA 30322
KING, STEPHEN 29 ACT PD
6667 VERNON WOODS DR NE, ATLANTA 30328
KING, WILLIAM D. 66 ACT OBG
PO BOX 367, TIFTON 31794
KING, WILLIAM R., JR. 59 ACT GS
708 SOUTH EIGHTH ST, GRIFFIN 30223
KINGLOFF, DANIEL L. 29 ACT ORS
490 PEACHTREE ST NE, ATLANTA 30308
KINLAW, WILLIAM K., JR. 22 ACT NS
370 WINN WAY STE 201, DECATUR 30030
KIRCHNER, ARTHUR B. 29 ACT R
5665 PEACHTREE-DUNWOODY RD, ATLANTA 30342
KIRKLAND, JAMES J. 42 ACT FP
MEDICAL CENTER, DUBLIN 31021
KIRKLAND, JOHN S. 27 ACT CDS
1825 MARTHA BERRY BLVD, ROME 30161
KIRKLAND, ROBERT A., JR. 22 ACT IM
1510 OAK GROVE RD STE 1, DECATUR 30033
KIRKPATRICK, J.F., JR. 66 ACT GS
PO BOX 929, TIFTON 31794
KIRKPATRICK, JAMES L. 17 ACT AN
PO BOX 564, MARIETTA 30060
KIRSH, ALAN D. 06 ACT R
4707 OXFORD RD, MACON 31210
KIRTLEY, THOMAS L., JR. 47 S FP
FAMILY PRACTICE CLINID, FT BENNING 31905
KISER, ELLEN F. 29 ACT P
2637 PEACHTREE RD NE #205, ATLANTA 30305
KISTLER, HENRY E. 60 ACT OBG
905 BIG A RD, TOCCOA 30577
KITCHENS, S.B. 70 ACT FP
DRAWER A, LAFAYETTE 30728
KITCHENS, WILLIAM R. 54 ACT TS,CDS
820 ST SEBASTIAN WAY, AUGUSTA 30904
KITCHIN, HOUSTON W. 60 R GP
RTE 2 BOX 2354, CLAYTON 30525
KITE, J.H. 29 ACT ORS
10151 GOLF CLUB DR, JACKSONVILLE, FL 32216
KLAUS, RICHARD M. 17 ACT ORS
1620 MULKEY RD UPPER LEVEL, AUSTELL 30001
KLEIMAN, SCOTT G. 17 ACT ORS
3910 AUSTELL RD, AUSTELL 30001
KLEIN, LUELLA M. 29 ACT OBG
25 PRESCOTT ST NE, ATLANTA 30308
KLEIN, STEVEN H. 13 I&R PD
1061 HOMEWOOD CT, DECATUR 30033
KLEMANN, GILBERT L. 54 ACT IM
1021-15TH ST #3, AUGUSTA 30901
KLEMANN, GILBERT S. 23 ACT OBG
1001 NORTH MONROE, ALBANY 31701
KLERIS, GEORGE S. 29 A PH
99 BUTLER ST SE, ATLANTA 30303
KLINE, RANDOLPH W. 29 ACT P
811 JUNIPER ST NE, ATLANTA 30308
KLINGBEIL, ROBERT T. 17 ACT PM
KENNESTONE HOSPITAL, MARIETTA 30060
KLOPMAN, ALEX Z. 29 ACT FP
1150 GRIMES BRIDGE RD, ROSWELL 30075
KLOPPER, RALPH M. 29 ACT P
456 EAST PACES FERRY RD NE, ATLANTA 30305
KLOPSTOCK, WILLIAM J. 29 ACT P
3280 HOWELL MILL RD STE 202, ATLANTA 30327
KLOSTER, GILBERT J. 29 ACT PS
5669 PEACHTREE-DUNWOODY RD, ATLANTA 30342
KLOTZ, HUGH A. 29 ACT OPH
993-C JOHNSON FERRY RD NE, ATLANTA 30342
KNAPP, WILLIAM S. 29 ACT CD,IM
3250 HOWELL MILL RD, STE 306, ATLANTA 30327
KNIGHT, EVELYN A. 22 ACT EM
PO BOX 8540, ATLANTA 30312
KNOWLES, JAMES B. 45 ACT PM
PO BOX 130, WARM SPRINGS 31830
KNOWLES, VAN CISE 23 ACT GS
PO BOX 2049, ALBANY 31701
KNOWLTON, GREGORY B. 29 ACT NEP
5669 PEACHTREE-DUNWOODY RD, ATLANTA 30342
KNOX, JOHN O., JR. 17 ACT ORS
211 CHICOPEE DR, MARIETTA 30060
KO, KWANG BIN 72 ACT AN
1908 ALICE ST, WAYCROSS 31501
KOBAYASHI, T. KENJI 29 ACT ORS
3890 E PONCE DE LEON AVE, CLARKSTON 30021
KOENIG, RONALD H. 29 ACT N
1680 MULKEY RD STE C, AUSTELL 30001
KOFFLER, BARRY A. 29 ACT ORS
1190 GRIMES BRIDGE RD, ROSWELL 30075
KOGANTI, PURNACHANORA RAO 47 ACT AN
PO BOX 2748, COLUMBUS 31902
KOLLA, IRIS S. 29 I&R
2537 ECHO DR NE, ATLANTA 30345
KOLMEIER, KARL H. 29 ACT IM
4555 NORTH SHALLOWFORD RD, CHAMBLEE 30338
KOLODNER, ROBERT M. 29 S P
1670 CLAIRMONT RD, DECATUR 30033
KOORNICK, ALAN R. 29 ACT OS
5669 PEACHTREE-DUNWOODY RD, ATLANTA 30342
KORANSKY, JACK R. 29 ACT GE
993-F JOHNSON FERRY RD NE, ATLANTA 30342
KORSOWER, ALLAN J. 29 ACT NS
3280 HOWELL MILL RD NW, ATLANTA 30327
KORT, HILTON I. 29 ACT OBG
960 JOHNSON FERRY RD, ATLANTA 30342
KOZINN, MARK A. 29 ACT N
2788 BAYARD ST, EAST POINT 30344
KRAKOW, RICHARD A. 29 ACT D
11050 CRABAPPLE RD #102, ROSWELL 30075
KRAL, ROBERT A. 29 ACT OBG
1720 OLD SPRINGHOUSE LN, ATLANTA 30338
KRAMER, JOHN H. 22 ACT OPH
4553 NORTH SHALLOWFORD RD, ATLANTA 30338
KRAMER, RUSSELL H. 29 ACT GE,IM
5667 PEACHTREE-DUNWOODY RD, ATLANTA 30342
KRATINA, FREDRIC K. 68 ACT GYN,P
1550 DOCTORS DR, LA GRANGE 30240
KRAUS, STEPHEN 17 ACT FP
1545 POWERS FERRY RD STE I, MARIETTA 30067

KRAUSS, JONATHAN SETH 54 ACT PTH
MEDICAL COLLEGE OF GEORGIA, AUGUSTA 30901
KRAVTIN, A.J. 47 ACT PD
1968 NORTH AVE, COLUMBUS 31901
KRAWIECKI, NICOLAS S. 54 ACT PD
MEDICAL COLLEGE OF GA CK286, AUGUSTA 30912
KREH, GUSTAVE M. 11 ACT PD
4 MEDICAL ARTS CTR, SAVANNAH 31405
KREIDER, RODNEY N. 16 ACT PD
1035 MAIN ST, FOREST PARK 30050
KREPPS, ARTHUR C., II 59 ACT OBG
503 SOUTH EIGHTH ST, GRIFFIN 30223
KRISSMAN, PAUL H. 29 ACT IM
340 BOULEVARO NE #238, ATLANTA 30312
KRONE, HOWARD B. 22 ACT ORS
484 IRVIN CT #220, DECATUR 30030
KRUGMAN, PHILIP I. 29 ACT OBG
3280 HOWELL MILL RO STE 337, ATLANTA 30327
KUDCHADKAR, SOMANATH G. 47 A DR
5051 YOSEMITE DR, COLUMBUS 31907
KUGLAR, HELEN B. 54 ACT OBG
1511 JOHNS RD, AUGUSTA 30904
KULKARNI, VASUDEV V. 06 ACT EM
4927 RIVOLI OR, MACON 31210
KULKIN, JAY 22 ACT OBG
5365 FIVE FORKS TRICKUM, LILBURN 30247
KUMAR, ASHOK 47 ACT NEP
500 - 18TH ST, COLUMBUS 31901
KUMAR, RAKESH 49 ACT GS
PO ORAWER 551, EATONTON 31024
KUMAR, SURENDER V. 32 ACT OBG
1004 THORNTON RD 103, LITHIA SPRINGS 30057
KUMAR, VEENI S. 32 ACT PTH
3327 HWY 5, DOUGLASVILLE 30134
KUMIN, GERALD D. 17 ACT IM
833 CAMPBELL HILL RO ' 340, MARIETTA 30090
KUNKES, JEFFREY A. 16 ACT OTO
6507 PROFESSIONAL PL, RIVERDALE 30274
KUO, MAX 23 ACT PD
810 - 13TH AVE, ALBANY 31701
KUPCUOGLU, ERDAL H. 16 ACT OTO
217-C ARROWHEAD BLVD, JONESBORO 30236
KUPSHIK, HILTON L. 29 ACT AN
35 COLLIER RD NW STE 560, ATLANTA 30309
KURTZ, DONALD M. 47 ACT PTH
PO BOX 4176, COLUMBUS 31904
KURTZ, JOSEPH L. 29 ACT ORS
2635 BROOKDALE DR NW, ATLANTA 30305
KURZBACH, ELMAR 11 OE4 GP
PO BOX 13144, SAVANNAH 31406
KUSKE, TERRENCE T. 54 ACT IM
MEDICAL COLLEGE OF GEORGIA, AUGUSTA 30912
KUSUMA, VITHAL 23 ACT IM
1009 NORTH MONROE ST STE 107, ALBANY 31701
KUTNER, STEPHEN S. 29 ACT OPH
353 PARKWAY DR NE, ATLANTA 30312
KWOK, KEN K. 59 ACT FP
PO BOX 561, ZEBULON 30295
KWON, OH BONG 15 ACT PD
1010 PRINCE AVE, ATHENS 30601
KYBURZ, BRUCE A. 17 ACT U
660 CHEROKEE, MARIETTA 30060

L

LABICHE, HENRY 47 ACT PTH
PO BOX 4176, COLUMBUS 31904
LABINER, DAVID M. 54 ST
MEDICAL COLLEGE OF GEORGIA, AUGUSTA 30912
LACKEY, DIXON A. 29 ACT PH
440 OLD CREEK RD NE, ATLANTA 30342
LACONTE, LEONARD P. 19 ACT R
BOX 608, MOULTRIE 31768
LADLEY, D. MARK 47 I&R
6006 OLO DOMINION RD, COLUMBUS 31904
LAHMAN, ROSE A. 29 ACT GYN
1234 POWERS FERRY RD ' 102, MARIETTA 30067
LAKE, FRANK G., III 34 ACT TR
147 OVERLOOK DR, GAINESVILLE 30505
LAKE, MICHAEL H. 47 ACT U
1021 TALBOTTON RD, COLUMBUS 31904
LAMAN, EDWARD N. 29 ACT AN
3030 NANCY CREEK RD, ATLANTA 30327
LAMB, CHARLES C. 23 ACT FP
910 NORTH JEFFERSON, ALBANY 31701
LAMB, GAIL L. 06 ACT EM
4800 MUMFORD RD, MACON 31204
LAMBERT, ROBERT Y. 17 ACT GS
2701 SUMMERS ST, KEWNNESAW 30144
LAMIS, PANO A. 29 ACT GS
315 BOULEVARD NE, ATLANTA 30312
LAMMERS, JOHN E. 54 I&R IM
1439 TROUPE ST, AUGUSTA 30904
LAMOTTE, IRENE F. 54 R DR
820 ST SEBASTIAN STE 1-A, AUGUSTA 30902
LAMPERT, SCOTT I. 29 ACT OPH
3280 HOWELL MILL RD STE 319, ATLANTA 30327
LAMPROS, C. PETER 60 ACT R
800 OOYLE ST, TOCCOA 30577
LANCASTER, CARLTON D., JR. 76 ACT IM
1209 MEMORIAL DR, DALTON 30720
LAND, WILLIAM C., JR. 16 ACT DR
119 UPPER RIVEROALE RD, RIVERDALE 30274
LANDHAM, JACKSON W., JR. 59 ACT IM
743 SOUTH EIGHTH ST, GRIFFIN 30223
LANDY, MICHAEL S. 29 ACT IM
2739 FELTON OR, EAST POINT 30344
LANE, CARL E. 06 ACT TS
770 PINE ST STE 300, MACON 31201
LANE, DONALD R. 29 ACT IM
5243 SNAPFINGER WOODS DR, DECATUR 30035
LANE, GEORGE M. 65 ACT R
PO BOX 736, THOMASVILLE 31792
LANE, MARIAN F. 55 ACT FP
106 EAST TELEPHONE ST, SYLVANIA 30467
LANE, W.K. 23 ACT U
810 13TH ST, ALBANY 31701
LANFORD, CHARLES A. 06 ACT FP
7405 IND HWY, MACON 31206
LANG, WILLIAM C., JR. 29 ACT R
3200 HOWELL MILL RD NW, ATLANTA 30327
LANGE, STEPHEN J., JR. 11 ACT AN
8 STEPHENSON AVE, SAVANNAH 31405
LANGE, STEPHEN J., SR. 11 ACT GP
509 LEE BLVD, SAVANNAH 31405
LANGFORD, R. ALAN 42 ACT D
BELLEVUE RD, OUBLIN 31021
LANGSAM, CHARLES L. 29 ACT
350 CARPENTER DR NE APT 824, ATLANTA 30328
LANGSTON, WILLIAM T. 34 ACT PD
650 BROAD ST SE, GAINESVILLE 30505
LANIER, BOB G. 29 ACT IM
3250 HOWELL MILL RD NW, ATLANTA 30327
LANIER, LONNIE R., JR. 11 ACT OBG
2 MEDICAL ARTS CENTER, SAVANNAH 31405
LANIER, WILLIS E. 29 ACT OBG
960 JOHNSON FERRY RO NE, ATLANTA 30342
LAPIDES, LEON 47 ACT OTO
DOCTORS BLDG STE 409, COLUMBUS 31901
LARDIN, WILLIAM A. 65 ACT AN
ARCHBOLD MEM HOSPITAL, THOMASVILLE 31792
LARIOSA, DIOSITA W. 23 ACT PD
520 FOURTH AVE, ALBANY 31701
LARRAURI, MANUEL S. 02 ACT P
CENTRAL STATE HOSPITAL, MILLEDGEVILLE 31061
LASALLE, HENRY 48 ACT FP
PO BOX 870, COVINGTON 30209
LASKEY, GARY M. 22 ACT R
755 COLUMBIA OR STE 205, DECATUR 30030
LASLIE, MICHAEL N. 23 ACT AN
2207 ASHFORO OR, ALBANY 31707
LASSITER, HOMER L. 58 ACT FP
ARLINGTON CITY HOSPITAL, ARLINGTON 31713
LASSITER, NOLAN M. 22 ACT IM
1276 MCCONNELL DR, DECATUR 30033
LATHAM, ELIZABETH B. 29 ACT PD
2245 GODBY RD, COLLEGE PARK 30349
LATHAN, S. ROBERT 29 ACT IM
1938 PEACHTREE RD NW STE 606, ATLANTA 30309
LAU, FOOK S. 02 ACT IM
297 YOUNGBLOOD CIR, MILLEDGEVILLE 31061
LAUBE, JUDITH M. 29 ACT AN
705 JUNIPER ST NE, ATLANTA 30308
LAUN, FREDERICK M. 08 ACT ORS
412 NORTHSIDE DR E, STATESBORO 30458
LAVIETES, PAUL A. 29 ACT R
35 LINDEN AVE NE, ATLANTA 30365
LAVIGNE, WILLIAM E. 54 ACT OBG
2042 CENTRAL AVE, AUGUSTA 30904
LAWHORNE, THOMAS W., JR. 47 ACT GS
2522 WARM SPRINGS RO, COLUMBUS 31904
LAWLER, JACK 47 ACT OBG
629 20TH ST, COLUMBUS 31904
LAWRENCE, DOUGLAS R. 27 ACT OBG
1105 NORTH 5TH AVE, ROME 30161
LAWRENCE, GEORGE C. 29 ACT OBG
75 PIEOMONT AVE NE, ATLANTA 30303
LAWRENCE, JAMES D. 06 ACT GS
380 HOSPITAL DR, MACON 31201
LAWRENCE, JOHN C. 60 ACT PO
800 EAST OOYLE ST, TOCCOA 30577
LAWRENCE, WILLIAM POWELL 54 ACT TR
820 ST SEBASTIAN WAY, AUGUSTA 30902
LAWS, WILLIAM J. 30 ACT IM
3212 SHRINE RD, BRUNSWICK 31520
LAWSON, QUENTIN T. 56 ACT U
401 WOOOROW WILSON DR, VALDOSTA 31602
LAWVER, ALICE I. 22 ACT N
495 WINN WAY STE 150, DECATUR 30030
LAYGO, ROMUALDO M. 11 ACT GS
PO BOX 348, SPRINGFIELD 31329
LAYNE, EDWARD A. 29 A IM,GE
2600 MLK JR OR SW. ATLANTA 30311
LAYNE, WILLIAM T. 17 ACT OBG
#5A, AUSTELL 30001
LAZO, RODOLFO S. 02 ACT GS
CENTRAL STATE HOSP, MILLEDGEVILLE 31062
LEACH, WILLIAM WALLACE 23 ACT OBG
1001 NORTH MONROE, ALBANY 31701
LEAR, THOMAS F., JR. 65 ACT GS
PO BOX 1912, THOMASVILLE 31792
LEBOS, HARVEY C. 11 ACT IM,HEM
PO BOX 23829, SAVANNAH 31403
LEBOW, H. GARY 68 ACT OM
PO BOX 71, WEST POINT 31833
LEE, DENNIS E. 29 ACT ORS
993 JOHNSON FERRY RD NE, ATLANTA 30342
LEE, EVERETT M. 13 ACT IM
PO BOX 653, CUMMING 30130
LEE, FRED M. 60 ACT U
800 EAST OOYLE ST, TOCCOA 30577
LEE, HOWARD B. 22 ACT FP
603 CHURCH ST, DECATUR 30030
LEE, J. MOULTRIE 11 ACT GS
200 EAST 31ST ST, SAVANNAH 31401
LEE, JOHN E. 29 ACT N
993-F JOHNSON FERRY RD NE, ATLANTA 30342
LEE, JOHN L. 29 ACT OBG
11050 CRABAPPLE RD, ROSWELL 30075
LEE, JOSEPH D. 54 ACT GS
3032 LAKE FOREST DR, AUGUSTA 30909
LEE, KUO LAM 50 ACT R
PO BOX 489, EASTMAN 31023
LEE, LAWRENCE, JR. 11 ACT IM
2203 ABERCORN ST, SAVANNAH 31401
LEE, LOUIS G. 65 ACT IM,GE
503 GOROON AVE, THOMASVILLE 31792

LEE, S. REAVES 29 ACT P
1493 LAVISTA RD NE, ATLANTA 30324
LEE, STEVEN R. 29 ACT P
3280 HOWELL MILL RD STE 336, ATLANTA 30327
LEE, WAI YEE 23 ACT PD
802 NORTH MONROE, ALBANY 31701
LEE, WALTER E., JR. 72 ACT FP
BOX 737, WAYCROSS 31501
LEEB, DIANNE CHERYL 22 ACT PS
1462 MONTREAL RD STE 411, TUCKER 30084
LEFF, PETER B. 22 ACT GE
487 WINN WAY STE 206, DECATUR 30030
LEFF, STEPHEN P. 22 ACT OPH
755 COLUMBIA DR STE 215, DECATUR 30030
LEFFERT, ROBERT L. 15 ACT PTH
ST MARYS HOSPITAL, ATHENS 30606
LEFKOFF, HAROLD J. 29 ACT OTO
315 BOULEVARD NE, ATLANTA 30312
LEHMAN, RONALO J. 48 ACT ORS
4555 NORTH SHALLOWFORD RD, DUNWOODY 30338
LEIGH, JAMES H., JR. 34 ACT GS
194 GOLD ST, GAINESVILLE 30505
LEIGH, RICHARD W. 27 ACT OBG
909 NORTH FIFTH AVE, ROME 30161
LEIGH, TED F. 29 ACT R
1803 ROCKRIDGE PL NE, ATLANTA 30324
LEMLEY, JOHN W. 44 ACT FP
PO BOX 300, THOMSON 30824
LEMON, RODMAN, JR. 54 ACT OBG
3614 J DEWEY GRAY CIR STE D, AUGUSTA 30909
LENNINGTON, B. RICHARO 06 ACT R
380 HOSPITAL DR STE 170, MACON 31201
LENNOX, KENNETH W. 54 ACT U
VA MEDICAL CENTER, AUGUSTA 30910
LEONARO, JAMES R. 29 ACT OTO
3280 HOWELL MILL RD STE 333, ATLANTA 30327
LEONARD, MICHAEL M. 06 I&R FP
777 HEMLOCK ST, MACON 31201
LEONARO, ROBERT 54 ACT OTO
1109 TELFAIR ST, AUGUSTA 30901
LEONARD, ROBERT P. 22 ACT PS
500 IRVIN CT STE C-250, DECATUR 30030
LEONARO, WILLIAM P. 29 ACT GS
3406 OLD PLANTATION RD NW, ATLANTA 30327
LEONARDY, JOHN G. 29 ACT IM
478 PEACHTREE ST NE, ATLANTA 30308
LERMAN, BERNARD 29 ACT GS
3280 HOWELL MILL RD STE 241, ATLANTA 30327
LESESNE, ARTHUR E. 29 ACT IM
575 WEST PEACHTREE ST NW, ATLANTA 30308
LESLIE, JOHN T. 22 R PH
19 WILTSHIRE DR, AVONDALE ESTATES 30002
LESSER, JOSEPH M., PH.O. 29 ACT IM
490 PEACHTREE ST STE 137-B, ATLANTA 30308
LESSER, LAURENCE M. 48 ACT IM,CD
1309 MILSTEAD RD, CONYERS 30207
LESSLIE, WILLIAM P. 17 ACT IM
86 SOUTH COBB DR, MARIETTA 30063
LESTER, JESS C. 29 ACT OPH
478 PEACHTREE ST NE, ATLANTA 30308
LESTER, WILLIAM M. 29 ACT OBG
5675 PEACHTREE-DUNWOODY RD, ATLANTA 30342
LETTON, A. HAMBLIN 29 ACT GS
315 BOULEVARD NE STE 500, ATLANTA 30312
LEVENSON, DAVID S. 22 ACT OPH
2754 NORTH DECATUR RD, DECATUR 30033
LEVERETT, EOWARD 68 ACT FP
303 SMITH ST, LA GRANGE 30240
LEVIN, FRED A. 48 ACT IM,GE
1309 MILSTEAD RD STE G, CONYERS 30207
LEVIN, HAROLD B. 29 ACT D
1293 PEACHTREE ST NE, ATLANTA 30309
LEVIN, JACK M. 29 ACT CRS
340 BOULEVARD NE, ATLANTA 30312
LEVINE, ALLAN N. 17 ACT ORS
3910 AUSTELL RD STE 101, AUSTELL 30001
LEVINE, KEITH A. 22 ACT OS
2754 NORTH DECATUR RD #104, DECATUR 30030
LEVINE, MARSHALL R. 29 ACT IM
2045 PEACHTREE RD NE STE 425, ATLANTA 30309
LEVINE, MICHAEL K. 29 ACT PD
6500 VERNON WOODS DR, ATLANTA 30328
LEVINE, MICHAEL S. 17 ACT GE
2550 WINDY HILL RD STE 203, MARIETTA 30067
LEVINE, RAPHAEL S. 22 ACT IM
487 WINN WAY STE 105, DECATUR 30030
LEVINE, STEPHEN B. 29 ACT OPH
5675 PEACHTREE-DUNWOODY RD, ATLANTA 30342
LEVITT, RICHARD A. 29 ACT PD
625 COLONIAL PARK DR STE 101, ROSWELL 30075
LEVY, ARTHUR J. 29 ACT TS
5667 PEACHTREE-DUNWOODY RD, ATLANTA 30342
LEVY, CHARLES E. 29 ACT P
5300 WILLOW POINT PKY, MARIETTA 30067
LEVY, JACK H. 54 ACT R
1450 WINTER ST, AUGUSTA 30902
LEVY, LOUIS I. 47 ACT PD
1968 NORTH AVE, COLUMBUS 31901
LEVY, LOUIS K. 29 R IM
2045 PEACHTREE RD NE, ATLANTA 30309
LEVY, ROBERT M. 16 ACT R
PO BOX 1255, RIVERDALE 30274
LEVY-ELICEIRI, CARLOS A. 24 ACT GS
905-A DILWORTH ST, ST MARYS 31558
LEWIS, EDWARD L., JR. 15 ACT D
1077 BAXTER ST, ATHENS 30601
LEWIS, JOHN GRANT 27 ACT IM
5 JOHN MADDOX DR, ROME 30161
LEWIS, JOHN R., JR. 29 ACT PS
3316 PIEDMONT RD NE, ATLANTA 30305
LEWIS, L.K. 49 ACT FP
BOX 552, MADISON 30650
LEWIS, MYRON KEITH 50 ACT IM
PULASKI PROFESS BLDG, HAWKINSVILLE 31036
LEWIS, WILEY B. 72 ACT OS
1507 ALICE ST, WAYCROSS 31501
LEWIS, WILLIAM EARL 06 ACT GS
380 HOSPITAL DR STE 430, MACON 31201
LEXOW, STEPHEN S. 22 ACT N
370 WINN WAY STE 103, DECATUR 30030
LEYVA, JOSE S. 16 ACT OBG
189 MEDICAL WAY, RIVERDALE 30274
LIBERMAN, HENRY A. 29 ACT IM,CD
25 PRESCOTT ST NE, ATLANTA 30308
LICHTMAN, STANLEY 29 ACT AN
2760-B FELTON DR, EAST POINT 30344
LIEBMAN, PAUL H. 16 ACT IM
217 ARROWHEAD BLVD, JONESBORO 30236
LIEPPE, WILLIAM M. 29 ACT CD
5669 PEACHTREE DUNWOODY RD, ATLANTA 30342
LIEVANO, ALVARO 29 ACT ORS
PO DRAWER T, EAST POINT 30344
LIGHT, GERALO S. 56 ACT PD
2704 NORTH OAK BLDG J, VALDOSTA 31602
LIGON, WALTER M. 17 ACT OTO
444 FAIRGROUND ST, MARIETTA 30060
LIM, ASTOR T. 30 ACT GP
103 SHERWOOD FOREST CIR, BRUNSWICK 31520
LIMEHOUSE, WALTER E., JR. 16 ACT PTH
33 UPPER RIVERDALE RD S22, RIVERDALE 30274
LIN, CHENG-HSIUNG 18 ACT OBG
PO BOX 1056, DOUGLAS 31533
LIN, GERALD 68 ACT U
303 SMITH ST, LA GRANGE 30240
LIN, HUI-CHING Y. 29 R PH
634 WILSON RD NW, ATLANTA 30318
LIN, TA JUNG 06 ACT OBG
PO BOX 6000, MACON 31208
LINDER, CHARLES W. 54 ACT PD
MEDICAL COLLEGE OF GEORGIA, AUGUSTA 30912
LINDSAY, JAMES B. 06 ACT GS
781 SPRING ST, MACON 31201
LINDSEY, I.L. 29 ACT N
993-F JOHNSON FERRY RD NE, ATLANTA 30342
LINDSEY, MARK M. 17 ACT FP
4430 PACES BATTLE NW, ATLANTA 30327
LINDYBERG, KENNETH R. 59 S GS
600 SOUTH 8TH ST, GRIFFIN 30223
LINE, ROBIN L. 29 ACT FP
90 WEST WIEUCA RD NE, ATLANTA 30342
LINGAM, N.R. 68 ACT EM
1550 DOCTORS DR STE 305, LA GRANGE 30240
LINTYMER, STEVE 47 ACT PTH
PO BOX 4176, COLUMBUS 31904
LINZ, WERNER A. 68 ACT U
303 SMITH ST, LA GRANGE 30240
LIPHAM, MARK L. 10 ACT IM
PO BOX 997, CARROLLTON 30117
LIPMAN, BERNARD S. 29 ACT IM
3280 HOWELL MILL RD STE 103, ATLANTA 30327
LIPPITT, WILLIAM H. 11 R GS
106 MCLAWS ST, SAVANNAH 31405
LIPSCOMB, GEORGE E. 47 ACT R
PO BOX 2787, COLUMBUS 31902
LIPSCOMB, THOMAS L. 29 ACT OM
3580 ATLANTA AVE, HAPEVILLE 30354
LIPSETT, NATHAN W. 16 ACT IM
29 SW UPPER RIVERDALE RD, RIVERDALE 30274
LIPSITCH, IAN I. 29 ACT P
5064 ROSWELL RD NE, ATLANTA 30342
LIPSITT, MICHAEL A. 13 ACT IM
719 SCENIC HWY, LAWRENCEVILLE 30245
LIPSON, ROBERT A. 17 ACT IM
166 VANN ST, MARIETTA 30090
LITTLE, ALEX G., JR. 56 R GS
RTE 1 BOX 4, VALDOSTA 31601
LITTLE, CHARLES H. 34 ACT ORS
700 SOUTH ENOTA DR NE, GAINESVILLE 30501
LITTLE, FRANK A. 65 R AN
109 TUXEDO DR, THOMASVILLE 31792
LITTLE, G.H. 27 ACT FP
15 PARK AVE, TRION 30753
LITTLE, RICHARD R. 29 ACT AN
5665 PEACHTREE DUNWOODY RD, ATLANTA 30342
LITTLE, ROBERT C. 54 ACT CD
MEDICAL COLLEGE OF GEORGIA, AUGUSTA 30912
LITTON, JAMES H. 22 ACT FP
4173 FIRST AVE, TUCKER 30084
LIVINGSTON, JAMES A. 06 ACT FP
PO BOX 590, BYRON 31008
LLORENTE, TEODULO M. 27 ACT FP
105 JOHN MADDOX DR, ROME 30161
LLOYO, PATRICIA K.A. 29 ACT IM
300 BOULEVARD BOX 476, ATLANTA 30312
LOCHRIDGE, E.P., JR. 29 ACT CRS
35 COLLIER RD NW, ATLANTA 30309
LOCKMAN, OAVID S. 15 ACT IM
700 OGLETHORPE, ATHENS 30606
LOCKRIDGE, JOHN B. 29 ACT P,CHP
5667 PEACHTREE DUNWOODY RD, ATLANTA 30342
LOOGE, CHARLES G. 47 I&R
PO BOX 2307, MOULTRIE 31768
LOEFFLER, JANICE H. 56 ACT PD
2704 NORTH OAK ST, VALDOSTA 31602
LOFTIS, WILLIAM EDWIN 54 ACT R
1427 HARPER ST, AUGUSTA 30909
LOFTMAN, BERT A. 29 ACT NS
105 COLLIER RD NW, ATLANTA 30309
LOGAN, J. ROBERT 11 ACT OTO
2203 ABERCORN ST, SAVANNAH 31401
LOGAN, WILLIAM D., JR. 29 ACT TS
272 BOULEVARD NE, ATLANTA 30312
LOGUE, R. BRUCE 29 ACT CD
25 PRESCOTT ST NE, ATLANTA 30308
LOHAUS, GERHARD H. 29 ACT IM
993-D JOHNSON FERRY RD NE, ATLANTA 30342
LOIS, THOMAS A. 13 ACT PS
2121 FOUNTAIN DR STE K, SNELLVILLE 30278

LOKEY, JULIAN L. 29 ACT ON
993-D JOHNSON FERRY RD NE, ATLANTA 30342
LONG, EUGENE M., JR. 54 ACT OBG
1810 CENTRAL AVE, AUGUSTA 30904
LONG, EUGENE ROY 68 ACT IM
CLARK HOLDER CLINIC, LA GRANGE 30240
LONG, HAROLD G. 43 ACT GP
PO BOX 186, DAHLONEGA 30533
LONG, HAROLD W. 50 ACT FP
PO BOX 400, EASTMAN 31023
LONG, LEONARD 29 R
PO BOX 277, CASHIERS NC 28717
LONG, ROBERT F. 11 ACT R
PO BOX 23089, SAVANNAH 31403
LONG, W.V. 11 ACT GS
540 EAST 49TH ST, SAVANNAH 31405
LONG, WILLIAM B. 29 ACT OPH
4957 LAVISTA RD, TUCKER 30084
LONGINO, GRADY E. 42 ACT IM
VA CENTER, DUBLIN 31021
LOOMIS, EARL A., JR. 54 ACT P,CHP
1515 POPE AVE, AUGUSTA 30912
LOOPER, BEN K. 14 ACT OBG
RTE 6 SUNSET DR, CANTON 30114
LOPEZ, AUGUSTO 61 ACT PTH
AMERICUS-SUMTER CO HOSP, AMERICUS 31709
LOPEZ, CARLOS E. 29 ACT IM
1938 PEACHTREE RD NW STE 204, ATLANTA 30309
LOPEZ, ERNESTO G. 72 ACT PTH
WAYCROSS MEMORIAL HOSPITAL, WAYCROSS 31501
LOPEZ, HECTOR H., JR. 16 ACT IM
33 SW UPPER RIVERDALE RD, RIVERDALE 30274
LOPEZ, JOSE 29 ACT AN
409 ARROWHEAD BLVD, JONESBORO 30236
LOPEZ, ORLANDO O. 16 ACT U
2739 FELTON DR, EAST POINT 30344
LOPEZ-LAGO, JOSE A. 47 ACT IM
PO BOX 5307, COLUMBUS 31906
LORD, CLYOE O. 29 A AN
501 FAIRBURN RD SW, ATLANTA 30331
LORENZ, MAX P. 17 ACT U
833 CAMPBELL HILL ST ' 290, MARIETTA 30090
LOTNER, GARY Z. 17 ACT A
2480 WINDY HILL RD STE 201, MARIETTA 30067
LOTT, DAN A. 72 ACT OBG
700 RIVERSIDE AVE, WAYCROSS 31501
LOTT, THOMAS M. 54 ACT R
PO BOX 10106, AUGUSTA 30903
LOUGHLIN, EDWARD C. 29 ACT ORS
1938 PEACHTREE RD NW, ATLANTA 30309
LOVELESS, GARY R. 08 ACT ORS
412 NORTHSIDE DR E, STATESBORO 30458
LOVETT, KATHRYN S. 08 ACT P
PO BOX 486, STATESBORO 30458
LOWANCE, DAVID C. 29 ACT IM
35 COLLIER RD NW STE 610, ATLANTA 30309
LOWANCE, MASON I. 29 ACT A
2734 PEACHTREE RD C-204, ATLANTA 30305
LOWE, THOMAS H. 06 ACT IM
618 ORANGE ST, MACON 31201
LOWENBERG, ROBERT I. 29 R GS,CD
5333 LONG ISLAND DR NW, ATLANTA 30327
LOWERY, WILLIAM D., JR. 23 ACT NS
PO BOX 625, ALBANY 31702
LOWREY, DARRELL G. 27 ACT ORS
1825 MARTHA BERRY BLVD, ROME 30161
LUCAS, GEORGE W. 29 ACT GS
340 BOULEVARD NE, ATLANTA 30312
LUCAS, STEPHEN K. 15 ACT IM
1010 PRINCE AVE #112, ATHENS 30606
LUCAS, WALLACE 36 ACT FP
613 E DYKES ST, COCHRAN 31014
LUCAS, WILLIAM H. 27 ACT IM
5 PROFESSIONAL CT, ROME 30163
LUCAS, WILLIAM T. 54 ACT U
1276 MERRY ST, AUGUSTA 30904
LUCCHESE, MARY CECILIA 29 I&R
81 WAKEFIELD DR NE, ATLANTA 30309
LUCKETT, JAMES M. 22 ACT R
2701 NORTH DECATUR RD, DECATUR 30033
LUCKEY, TOM M. 22 ACT IM
711 CHURCH ST, DECATUR 30030
LUKE, B.D. 16 ACT FP
6103 NORTH MAIN ST, MORROW 30260
LULL, CHARLES ROBERTS 76 ACT R
PO BOX 2066, DALTON 30720
LUMPKIN, MURRAY B. 76 ACT GS
PO BOX 987, DALTON 30720
LUMPKIN, WILLIAM H. 76 ACT GS
PO BOX 987, DALTON 30720
LUMSDEN, THOMAS N. 33 ACT FP
PO BOX 45, CLARKESVILLE 30523
LUND, ROBERT W. 29 ACT IM
35 COLLIER RD NW STE 425, ATLANTA 30309
LUXENBERG, MALCOLM N. 54 ACT ORS
1120 15TH ST, AUGUSTA 30912
LYKINS, LAWRENCE E. 34 ACT U
1114 VINE ST NE, GAINESVILLE 30505
LYNCH, DONALD RICHARD 72 ACT FP
1514 ST MARYS DR, WAYCROSS 31501
LYNCH, EDWIN H. 34 ACT OBG
1100 VINE ST, GAINESVILLE 30501
LYNCH, LAWRENCE J., JR. 11 ACT GS
5400 SUTLIVE ST STE 2, SAVANNAH 31405
LYNN, KAY F. 22 ACT OBG
5040 SNAPFINGER WOODS DR, DECATUR 30035
LYNN, RONALD B. 27 ACT N
327 TURNER MCCALL BLVD, ROME 30161
LYON, DAVID B. 29 ACT P
2151 PEACHFORD RD, ATLANTA 30338
LYON, JAMES B. 29 ACT OBG
105 COLLIER RD NW STE 3080, ATLANTA 30309
LYONS, THOMAS L. 15 ACT OBG
740 PRINCE AVE, ATHENS 30601

M

MA'LUF, TANIOS J. 68 ACT OBG
303 SMITH ST, LA GRANGE 30240
MABON, ROBERT 29 ACT NS
3053 ANDREWS DR NW, ATLANTA 30305
MACCAUGHELTY, T. CAMERON 08 ACT AN
PO BOX 567, STATESBORO 30458
MACHADO, M.D. 29 ACT AN
3830 SOUTH COBB DR STE 213, SMYRNA 30080
MACIAS, F.M. 59 ACT AN
24 MAIN ST, HAMPTON 30228
MACLEOD, OAVID S. 27 ACT CD
HARBIN CLINIC, ROME 30161
MACNABB, GEORGE M. 20 ACT IM
58 HOSPITAL RD STE 106, NEWNAN 30263
MACNEILL, CHARLES A. 29 ACT AN
5675 PEACHTREE DUNWOODY RD, ATLANTA 30342
MACON, PHILIP F. 29 ACT ORS
5667 PEACHTREE-DUNWOODY RD, ATLANTA 30342
MACRIS, ALLEN G. 29 ACT TS
490 PEACHTREE ST NE, ATLANTA 30308
MACWILLIAMS, PETER 29 ACT D
1001 THORNTON RD 803, LITHIA SPRINGS 30057
MADDOX, HUGH G., JR. 10 ACT AN
PO BOX 1084, CARROLLTON 30117
MADDOX, S.F. 06 ACT OPH
800 FIRST ST, MACON 31201
MADELEY, JAMES B. 22 ACT ORS
1462 MONTREAL RD STE 114, TUCKER 30084
MAFFETT, MICHAEL E. 29 A IM
4735 WOODVALE DR NW, ATLANTA 30327
MAGAT, A.B., JR. 46 ACT GS
24 SOUTH ELLIS ST, CAMILLA 31730
MAGAT, WILFRIDO M. 13 ACT AN
2121-B FOUNTAIN DR, SNELLVILLE 30278
MAGILL, DANIEL H. 15 ACT CD
700 OGLETHORPE AVE, ATHENS 30606
MAGNAN, C.G., JR. 06 ACT PS
380 HOSPITAL DR, MACON 31201
MAGRUDER, RICHARD L., JR. 54 ACT IM
820 ST SEBASTIAN STE 5-A, AUGUSTA 30902
MAHAN, D.R., JR. 76 ACT FP
1219 MEMORIAL DR, DALTON 30720
MAHAN, THOMAS P. 29 ACT AN
35 COLLIER RD NW, ATLANTA 30309
MAHOLICK, LEONARD T. 29 ACT P
3316 PIEDMONT RD NE, ATLANTA 30326
MAHON, THOMAS M. 22 ACT PD
4112 E PONCE DE LEON AVE, CLARKSTON 30021
MAHONEY, PAUL D. 54 ACT AN
3208 MONTPELIER DR, AUGUSTA 30909
MAINOR, ROBERT 17 ACT FP
2874 KING ST SE, SMYRNA 30080
MAJANOVIC, MAHMUD 02 ACT PUD
914 RIVERBEND DR, MILLEDGEVILLE 31061
MAJEED, SHAHUL H.A. 70 ACT OBG
1816 LAFAYETTE RD, FT OGLETHORPE 30742
MAJOR, CECIL P. 68 ACT FP
303 SMITH ST, LA GRANGE 30240
MALCOM, GEORGE E., JR. 17 ACT EM
1355 WOODSTOCK RD, ROSWELL 30075
MALENBAUM, BRUCE T. 17 ACT OTO,MFS
1790 MULKEY RD STE 7, AUSTELL 30001
MALIK, ANWAR K. 56 ACT PD
104 WOODROW WILSON, VALDOSTA 31602
MALLARI, RAYMUNDO T. 16 ACT IM
238 PROFESSIONAL CT, RIVERDALE 30274
MALLORY, JAMES D., JR. 29 ACT P
4350 GEORGETOWN SQ, ATLANTA 30338
MALLOY, TYRONE C. 22 ACT OBG
2853 CANDLER RD STE 4, DECATUR 30034
MALMBORG, JOHN C. 72 ACT OBG
1404 TEBEAU ST, WAYCROSS 31501
MALONE, ELLIS L. 17 ACT IM
3910 AUSTELL RD STE 203, AUSTELL 30001
MALONE, PATRICK T. 29 ACT P
6363 ROSWELL RD NE, ATLANTA 30328
MALONE, RANDOLPH A. 65 ACT PD
509 GORDON AVE, THOMASVILLE 31792
MALONE, THOMAS NATHAN 47 ACT OBG
MEDICAL ARTS BLDG, COLUMBUS 31901
MALONE, VIRGINIA G. 29 DE2 IM
99 CONNEMARA RD, ROSWELL 30075
MALONEY, G. RUFUS 54 I&R U
3522 IRONWOOD DR, AUGUSTA 30907
MANCHESTER, P. THOMAS, JR. 29 ACT OPH
35 COLLIER RD NW, ATLANTA 30309
MANDAL, ANIL K. 54 ACT IM,NEP
VA MEDICAL CENTER 111F, AUGUSTA 30910
MANDEL, SAMUEL 06 ACT AN
PO BOX 6000, MACON 31208
MANER, F. DEBELE 11 ACT IM
2203 ABERCORN ST, SAVANNAH 31401
MANFREDI, JOHN A. 22 ACT ON
2054-E LAWRENCEVILLE HWY, DECATUR 30033
MANGANIELLO, LOUIS O.J. 54 ACT NS
820 ST SEBASTIAN WAY STE 6-B, AUGUSTA 30902
MANGET, J.D., JR. 29 ACT FP
1879 GREYSTONE RD NW, ATLANTA 30318
MANI, MURUGIAH 29 ACT AN
353 PARKWAY DR NE, ATLANTA 30312
MANIS, ROBERT 29 ACT P
4167 ROSWELL RD NE, ATLANTA 30342
MANN, DAVID S. 06 ACT FP
645 FIRST ST, MACON 31201
MANN, FRANK R., JR. 42 ACT GP
TELFAIR MEDICAL GROUP, MCRAE 31055
MANNES, HARVEY A. 32 ACT U
1001 THORNTON RD, 205, LITHIA SPRINGS 30057
MANNING, DONALD E. 29 ACT P
1365 CLIFTON RD NE, ATLANTA 30322

MANNING, DONALD H. 30 ACT R
3010 HAMPTON AVE, BRUNSWICK 31520
MANNING, JAMES H. 17 ACT GS
50 PLAZA WAY, MARIETTA 30060
MANNING, JOHANN R. 36 ACT OBG
105 BRIARCLIFF RD, WARNER ROBINS 31093
MANNO, JOSEPH A., III 29 ACT OPH
3280 HOWELL MILL RD NW, ATLANTA 30327
MANNS, WILLIAM J. 23 ACT IM
1909 ABERDEEN STE 101, ALBANY 31701
MANSBERGER, ARLIE 54 ACT GE
MEDICAL COLLEGE OF GEORGIA, AUGUSTA 30912
MANSFIELD, DONALD L. 22 ACT OBG
484 IRVIN CT STE 230, DECATUR 30030
MANSOUR, KAMAL A. 29 ACT TS
1365 CLIFTON RD NE, ATLANTA 30322
MANUS, RICHARD C. 17 ACT FP
1668 MULKEY RD, AUSTELL 30001
MANUS, WILLIAM A. 34 ACT FP
668 LANIER PARK DR NE, GAINESVILLE 30501
MAPLES, RUSSELL V. 59 ACT IM,PUD
23L GRAEFE ST, GRIFFIN 30223
MARAMREDDY, KRUPAVATBI 72 ACT PD
1921 ALICE ST, WAYCROSS 31501
MARAMREDDY, P. 72 ACT IM
415 ALBANY AVE, WAYCROSS 31501
MARASCALCO, ROBERT J. 34 ACT ORS
660-A LANIER PARK DR NE, GAINESVILLE 30505
MARCHMAN, MARVIN L. 29 ACT FP
6185 SOUTH BUFORD HWY, NORCROSS 30071
MARCUCCI, MIGUEL A. 29 ACT CDS
4760 AUSTELL RD, AUSTELL 30001
MARCUS, ROBERT D. 47 ACT OTO
2320 HAMILTON RD, COLUMBUS 31904
MARGESON, RICHARD C. 29 ACT GS
1938 PEACHTREE RD NW, ATLANTA 30309
MARGOLIS, BASIL 29 ACT IM,CD
5669 PEACHTREE-DUNWOODY RD, ATLANTA 30342
MARINKOVIC, STEVEN 13 ACT P,N
100 EAST CLAYTON ST, LAWRENCEVILLE 30245
MARKHAM, JOHN C., III 54 ACT GE
1514 ANTHONY RD, AUGUSTA 30904
MARKLE, C. DAVID 17 ACT IM
3910 AUSTELL RD STE 203, AUSTELL 30001
MARKS, THOMAS W. 29 ACT ORS
315 BOULEVARD NE STE 400, ATLANTA 30312
MARLOW, JAMES E. 76 ACT FP
1714 CLEVELAND AVE, DALTON 30720
MARMER, ROBERT H. 29 ACT OPH
777 CLEVELAND AVE SW, ATLANTA 30315
MARSCHALK, F.F., JR. 54 ACT IM
1500 JOHNS RD, AUGUSTA 30904
MARSH, DUNCAN R. 23 ACT ORS
810 - 14TH AVE, ALBANY 31708
MARSHALL, A. SMOAK 36 ACT GS
725 NORTH CAMELLIA BLVD, FORT VALLEY 31030
MARSHALL, LOUIE W. 54 ACT P
2301 WRIGHTSBORO RD, AUGUSTA 30904
MARSICANO, ANTHONY R. 11 ACT FP
602 EAST 67TH ST, SAVANNAH 31405
MARTENS, LESTER J. 27 ACT IM
321 TURNER MCCALL BLVD, ROME 30161
MARTIN, DAN ALLEN 13 ACT GS
PO BOX 347, LAWRENCEVILLE 30246
MARTIN, ELISABETH 13 R OBG
PO BOX 946, CUMMING 30130
MARTIN, FREDERICK W. 10 ACT OBG
AMBULANCE DR, CARROLLTON 30117
MARTIN, H.U. 76 ACT R
PO BOX 1285, DALTON 30720
MARTIN, J.D., JR. 29 R GS
230 ROBIN HOOD RD NE, ATLANTA 30309
MARTIN, J.O. 06 ACT OPH
745 PINE ST, MACON 31201
MARTIN, JAMES B. 23 ACT GYN
235 ROOSEVELT AVE STE 124, ALBANY 31701
MARTIN, JOHN M. 54 ACT IM
1258 MERRY ST, AUGUSTA 30904
MARTIN, LEE A. 34 ACT U
1114 VINE ST NE, GAINESVILLE 30505
MARTIN, ROBERT B., III 53 R GS
201 RANDOLPH ST, CUTHBERT 31740
MARTIN, ROGER P. 34 ACT OBG
254 SOUTH ENOTA DR, GAINESVILLE 30501
MARTIN, TALMADGE M. 10 ACT GS
619 DIXIE ST, CARROLLTON 30117
MARTIN, WALTER D. 53 R FP
PO BOX 70, DAWSON 31742
MARTIN, WILLIAM B. 13 ACT GP,IM
488 GWINNETT DR SW, LAWRENCEVILLE 30245
MARTIN, WILLIAM D. 16 ACT OBG
189 MEDICAL WAY STE B, RIVERDALE 30274
MARTIN, WILLIAM O., III 29 ACT OPH
1938 PEACHTREE RD NW, ATLANTA 30309
MARTINEZ, A.C. 02 ACT IM
PO BOX 677, MILLEDGEVILLE 31061
MARTINEZ, CARLOS B. 14 ACT FP
BOX 453 MAIN ST, BALL GROUND 30107
MARTINEZ, JOSEPH 72 ACT AN
MEMORIAL HOSPITAL, WAYCROSS 31501
MARTINEZ, MARCIAL E. 66 ACT R
PO BOX 3216, VALDOSTA 31601
MARTYNSKI, STANISLAW 70 ACT PD
JL HUTCHESON MEM HOSP, FT OGLETHORPE 30742
MASHBURN, MARCUS, JR. 13 ACT OBG
PO BOX 669, CUMMING 30130
MASON, EDWARD M. 29 ACT GS
315 BOULEVARD NE STE 500, ATLANTA 30312
MASON, JAMES L. 22 ACT P
1365 CLIFTON RD NE, ATLANTA 30322
MASON, M.H. 13 ACT FP
PO BOX 248, DULUTH 30136
MASON, MILES H., III 13 ACT GS
PO BOX 869, DULUTH 30136
MASON, W. ROY, JR. 29 R IM
1131 SPRINGDALE RD NE, ATLANTA 30306
MASON, WILLIAM A. 29 R PH
620 PEACHTREE ST NE, ATLANTA 30308
MASROOR, MOHAMMAD A. 11 ACT IM,CD
5354 REYNOLDS ST STE 212, SAVANNAH 31405
MASSEE, JOSEPH C. 29 ACT IM
21 EIGHTH ST NE, ATLANTA 30309
MASSENGALE, L.R. 54 ACT PD
1903 ROCK SPRINGS DR, AUGUSTA 30904
MASSEY, CLINTON E. 54 I&R NS
MEDICAL COLLEGE OF GEORGIA, AUGUSTA 30912
MASSEY, JOE B. 29 ACT OBG
960 JOHNSON FERRY RD NE, ATLANTA 30342
MATHENY, JAMES T. 27 ACT PD
16 HOSPITAL CIR, ROME 30161
MATHEWS, W. STANLEY 22 ACT PD
2100 PARK LAKE DR NE STE 15, ATLANTA 30345
MATHIS, JAMES W. 56 ACT GS
2704 NORTH OAK ST, VALDOSTA 31602
MATHIS, W.H., JR. 17 ACT R
70 TOWER RD, MARIETTA 30060
MATTAS, ANNE T. 54 ACT IM
MEDICAL COLLEGE OF GEORGIA, AUGUSTA 30904
MATTHEW, ROBERT A. 23 ACT AN
1625 LOWELL LN, ALBANY 31707
MATTHEWS, LAWRENCE P. 22 ACT OBG
1357 OXFORD RD NE, ATLANTA 30307
MATTHEWS, SANFORD J. 29 ACT PD
1938 PEACHTREE RD NW, ATLANTA 30309
MATTHEWS, W. FRANK 22 ACT PTH
2701 NORTH DECATUR RD, DECATUR 30033
MATTISON, RICHARD C. 22 ACT PS
993 JOHNSON FERRY RD NE, ATLANTA 30342
MAUGHON, BOB R. 47 ACT P
1953 SEVENTH AVE, COLUMBUS 31904
MAUGHON, JAMES S. 29 ACT GS
300 BOULEVARD NE, ATLANTA 30312
MAULDIN, JOHN T. 29 ACT GS
1422 WEST PEACHTREE ST NW, ATLANTA 30309
MAULDIN, JOHN W. 13 ACT FP
1081 29 HWY S, LAWRENCEVILLE 30245
MAURIZI, CHARLES P. 06 ACT PTH
3049 MALVERN HILL DR, MACON 31201
MAXEY, CLARENCE O. 22 ACT AN
755 COLUMBIA DR STE 413, DECATUR 30030
MAXEY, JOY A. 54 I&R
605 LENOX WAY, ATLANTA 30324
MAXWELL, G. DAVID 15 ACT GS
1010 PRINCE AVE, ATHENS 30606
MAXWELL, ROBERT B. 65 ACT PD
509 GORDON AVE, THOMASVILLE 31792
MAXWELL, THERESE A. 76 ACT IM
PO BOX 1924, DALTON 30720
MAY, CHARLES B. 06 ACT OBG
380 HOSPITAL DR, MACON 31201
MAY, STEPHEN C., JR. 17 ACT FP
2931 SOUTH MAIN ST, KENNESAW 30144
MAY, WILLIAM E. 06 ACT IM
380 HOSPITAL DR STE 460, MACON 31201
MAYBERRY, WILLIAM S. 15 ACT FP
120 WOODLANDS DR, WATKINSVILLE 30677
MAYER, W. BREM, JR. 29 ACT N
25 PRESCOTT ST NE 4TH FLOOR, ATLANTA 30308
MAYES, ALVA LOUIE, JR. 06 ACT PD
2009 VINEVILLE AVE, MACON 31204
MAYHER, WILLIAM E., III 23 ACT NS
PO BOX 625, ALBANY 31702
MAYO, EDWIN A. 30 ACT FP
3215 SHRINE RD, BRUNSWICK 31520
MAYO-ROJAS, HENRY 47 ACT CD,IM
2300 MANCHESTER EXPY, COLUMBUS 31904
MAYS, WALLACE D. 61 ACT OBG
401 SOUTH LEE ST, AMERICUS 31709
MAZIAR, HOWARD M. 29 ACT P
3400 PEACHTREE RD STE 1211, ATLANTA 30326
MAZO, MILTON 11 ACT PD
4 MEDICAL ARTS CENTER, SAVANNAH 31499
MAZUR, W.P. 29 ACT P
490 PEACHTREE ST STE 101-C, ATLANTA 30308
MCALISTER, BRADWELL R. 34 ACT ORS
650 BROAD ST SE, GAINESVILLE 30505
MCALISTER, ROBERT E. 29 ACT FP,OM
5635 PEACHTREE PKY, NORCROSS 30092
MCALLISTER, KATHRYN 47 ACT FP
PO BOX 951, COLUMBUS 31902
MCALLISTER, ROBERT W. 06 ACT P
1627 TWIN PINE DR, MACON 31211
MCALLISTER, YVONNE P. 06 I&R FP
784 SPRING ST, MACON 31201
MCALPINE, W. ESTHER 11 ACT PD
5354 REYNOLDS ST, SAVANNAH 31405
MCANULTY, MARTHA J. 22 ACT P
3081 MAPLE DR NE, ATLANTA 30305
MCARTHUR, JOHN D. 57 ACT GS
601 NORTH LANIER ST, LYONS 30436
MCBRIDE, WALTER W. 17 ACT IM
52 TOWER RD, MARIETTA 30060
MCCAIN, ARTHUR H. 22 I&R R
719 WEST PONCE DE LEON AVE, DECATUR 30030
MCCALL, CHARLES S., JR. 23 ACT IM
412 FOURTH AVE, ALBANY 31701
MCCANN, SANDRA BRIGGS 47 ACT R
DRAWER 2787, COLUMBUS 31902
MCCARD, RAY H. 06 ACT P
596 ARLINGTON PL, MACON 31201
MCCARVER, W.C., JR. 34 ACT FP
200 PRIOR ST SE, GAINESVILLE 30501
MCCLARIN, WILLIAM M., JR. 72 ACT D
202 FOLKS ST, WAYCROSS 31501
MCCLATCHEY, WILLIAM M. 29 ACT IM
35 COLLIER RD NW STE 775, ATLANTA 30309
MCCLELLAN, M.M., JR. 16 ACT PD
1035 MAIN ST, FOREST PARK 30050

MCCLELLAN, WILLIAM M. 68 ACT IM
303 SMITH ST, LA GRANGE 30240
MCCLELLAND, W. SPENCE 29 R IM
20 MOUNT PARAN RD NE, ATLANTA 30342
MCCLURE, CHARLES G. 54 ACT N
1029 CHAFEE AVE, AUGUSTA 30904
MCCLURE, E. RUTH 17 ACT OBG
732 CHEROKEE ST, MARIETTA 30060
MCCLURE, JOHN N., JR. 13 ACT GS
210 DAHLONEGA ST STE 104, CUMMING 30130
MCCOLLUM, WILLIAM 65 ACT PTH
ARCHBOLD MEM HOSPITAL, THOMASVILLE 31792
MCCORD, CLINTON D., JR. 29 ACT OPH
1938 PEACHTREE RD NW STE 103, ATLANTA 30309
MCCORD, OALE L. 29 ACT TR
1000 JOHNSON FERRY RD NE, ATLANTA 30342
MCCORD, GEORGE, JR. 17 ACT R
70 TOWER DR, MARIETTA 30060
MCCORD, JAMES W. 54 ACT N
1514 ANTHONY RD, AUGUSTA 30904
MCCORMICK, GLENN E., JR. 22 ACT D
755 COLUMBIA DR STE 806, DECATUR 30030
MCCOY, JOHN M. 29 ACT IM,RHU
993-C JOHNSON FERRY RD NE, ATLANTA 30342
MCCOY, MICHAEL J. 13 ACT OBG
4765 HIGHWAY 778 STE A, LILBURN 30247
MCCRANEY, JOHN M., JR. 29 ACT AN
35 LINDEN AVE, ATLANTA 30365
MCCRANIE, MARTHA S. 54 ACT P
742 LANCASTER RD, AUGUSTA 30909
MCCRARY, GEORGE A. 68 ACT ORS
303 SMITH ST, LA GRANGE 30240
MCCROSKEY, MARION M. 29 ACT AN
315 BOULEVARD NE STE 100, ATLANTA 30312
MCCRUM, B.A. 34 ACT GYN
420 BROAD ST, GAINESVILLE 30501
MCCUE, SEAN F. 06 ACT ORS
167 RIVERSIDE DR, MACON 31201
MCCUISTON, C.F. 22 ACT IM
3610 CHAMBLEE-TUCKER RD, CHAMBLEE 30341
MCCULLOUGH, RICHARD E. 66 ACT IM
BOX 947, TIFTON 31794
MCOANIEL, F. ELLEN 61 ACT DR
AMERICUS/SUMTER CO HOSPITAL, AMERICUS 31709
MCDANIEL, J. STUART 29 ACT OBG
105 COLLIER RD NW STE 1080, ATLANTA 30309
MCDANIEL, J.G. 29 ACT GP
820 WEST WESLEY RD NW, ATLANTA 30327
MCDANIEL, J.Z. 23 ACT U
1113 TENTH AVE, ALBANY 31707
MCDANIEL, WILLIAM L., JR. 76 ACT FP
1114 PROFESSIONAL BLVD, DALTON 30720
MCDONALD, ALLEN P. 29 ACT ORS
315 BOULEVARD NE STE 400, ATLANTA 30312
MCDONALD, HAROLD P., JR. 29 ACT U
98 CURRIER ST NE, ATLANTA 30308
MCDONALD, J. KENNETH 54 ACT P
3623 J DEWEY GRAY CIR ' 206, AUGUSTA 30909
MCDONALD, J.J. 15 ACT GS
740 PRINCE AVE, ATHENS 30601
MCDONALD, LEWIS H. 29 ACT GS
3665 IVY RD, ATLANTA 30342
MCDONOUGH, L.ALLEN 29 ACT PD
960 JOHNSON FERRY RD NE, ATLANTA 30342
MCDONOUGH, PAUL G. 54 ACT OBG
TALMADGE MEMORIAL HOSPITAL, AUGUSTA 30912
MCDOUGALL, WILLIAM L., JR. 29 ACT U
3250 HOWELL MILL RD NW, ATLANTA 30327
MCDOWELL, CHARLES W., JR. 22 ACT OPH
PO BOX 1798, DECATUR 30030
MCDUFFIE, FREDERIC C. 29 A RHU
1314 SPRING ST NW, ATLANTA 30309
MCELHANNON, F.M. 15 ACT GS
740 PRINCE AVE, ATHENS 30601
MCELHANNON, FAYETTE M., JR. 15 ACT ORS
1000 HAWTHORNE AVE, ATHENS 30610

MCEVER, VIRGLE W., JR. 36 ACT GS
105-B BRIARCLIFF, WARNER ROBINS 31093
MCGAHEE, OLLIE O., JR. 75 ACT FP
PO BOX 937, JESUP 31545
MCGAHEE, ROBERT C. 54 ACT PD
2817 HILLCREST AVE, AUGUSTA 30909
MCGARITY, SEABORN S., JR. 54 ACT P
820 ST SEBASTIAN WAY STE 3-D, AUGUSTA 30902
MCGARITY, WILLIAM C. 29 ACT GS
1365 CLIFTON RD NE, ATLANTA 30322
MCGARITY, WILLIAM C., JR. 29 ACT IM
575 WEST PEACHTREE ST NE, ATLANTA 30308
MCGEE, HARRY H., JR. 11 ACT R
311 EAST HALL ST, SAVANNAH 31401
MCGEE, THEODORE J. 47 ACT GS
2300 MANCHESTER EXPY, COLUMBUS 31904
MCGEHEE, JOHN M. 27 ACT GS
223 JULE PEEK AVE, CEDARTOWN 30125
MCGHEE, EARL T. 76 ACT FP
1012 BURLEYSON DR, DALTON 30720
MCGINNIS, JOHN C. 11 A PM
9830 SOUTH OSWEGO, TULSA OK 74136
MCGINNIS, LAMAR S., JR. 22 ACT GS
365 WINN WAY STE 201, DECATUR 30030
MCGINTY, A. PARK 29 ACT IM
3290 WOOD VALLEY RD NW, ATLANTA 30327
MCGINTY, W.R. 19 R U
RTE 4, MOULTRIE 31768
MCGOLDRICK, THOMAS A., JR. 11 ACT IM
15 EAST GORDON ST, SAVANNAH 31401
MCGRAW, WALKER C. 29 ACT GS
6185 SOUTH BUFORD HWY C-112, NORCROSS 30071
MCGUGAN, A. DAVID 11 ACT D
46 MEDICAL ARTS, SAVANNAH 31405
MCKEE, DAVID S. 29 ACT
1230 JOHNSON FERRY RD, MARIETTA 30067
MCKENNEY, JOEL RAY 54 ACT P
1500 JOHNS RD, AUGUSTA 30904
MCKENZIE, DONALD J. 65 ACT U
935 SOUTH BROAD ST, THOMASVILLE 31792
MCKENZIE, WILLIAM J., JR. 29 ACT OBG
5675 PEACHTREE-DUNWOODY RD, ATLANTA 30342
MCKERNAN, J. BARRY 17 ACT GS
130 VANN ST STE 220, MARIETTA 30060
MCKINNEY, ALEXANDER S. 29 ACT N
1365 CLIFTON RD NE, ATLANTA 30322
MCKINNEY, JAMES E. 76 ACT U
1109 BURLEYSON DR, DALTON 30720
MCKINNEY, RAY L. 23 ACT R
PO BOX 1924, ALBANY 31703
MCKINNON, FRANK W. 17 ACT ORS
652 CHURCH ST, MARIETTA 30060
MCKINNON, WILLIAM M. 29 ACT CDS
1942 BRECKENRIDGE DR, ATLANTA 30345
MCKNIGHT, ROBERT R. 54 R ORS
1134 DRUID PARK AVE, AUGUSTA 30904
MCLAIN, E.K. 54 ACT IM
748 LANCASTER RD STE A, AUGUSTA 30909
MCLANE, JOHN E. 22 ACT OBG
365 WINN WAY STE 251, DECATUR 30030
MCLAREN, JOHN R. 02 ACT R
1365 CLIFTON RD NE, ATLANTA 30322
MCLARTY, W. THERON, JR. 17 ACT P
3985 SOUTH COBB DR, SMYRNA 30080
MCLEAN, DONALD C. 29 ACT A
1938 PEACHTREE RD NW, ATLANTA 30309
MCLEAN, FREDERICK L. 79 ACT FP
407 MCPHAUL ST, SYLVESTER 31791
MCLEAN, WILLIAM R. 17 ACT PD
74 MEDICAL SQ, MARIETTA 30060
MCLENDON, HAROLD L. 10 ACT OBG
115 HOSPITAL DR, CARROLLTON 30117
MCLENDON, JOE L. 06 ACT OPH
BACONSFIELD OFFICE PK, MACON 31211
MCLENDON, JULIAN K. 10 ACT US
405 ALABAMA AVE, BREMEN 30110

MCLENDON, REMBERT L. 23 ACT ORS
803 NORTH JEFFERSON ST, ALBANY 31701
MCLEOD, DONALD S. 29 ACT AN
5675 PEACHTREE DUNWOODY RD, ATLANTA 30342
MCLEOD, HUGH C., III 17 ACT ORS
211 CHICOPEE DR, MARIETTA 30060
MCLEOD, JOHN W. 19 ACT GS
1323 SOUTH MAIN ST, MOULTRIE 31768
MCLEOD, KEVIN 47 I&R
PO BOX 951, COLUMBUS 31994
MCLEOD, NATLIE BOWEN 54 I&R NTR
422 ASHLAND DR, AUGUSTA 30909
MCLEOD, WALLACE N. 29 ACT D
340 BOULEVARD NE, ATLANTA 30312
MCLEOD, WALLACE N., JR. 54 ACT OPH
3640 WHEELER RD, AUGUSTA 30909
MCMAHAN, HOWARD C. 78 ACT FP
212 HOSPITAL DR, WASHINGTON 30673
MCMICHAEL, ALICE O. 54 ACT P
3643 WALTON WAY EXT, AUGUSTA 30909
MCMICHAEL, ROBERT S. 06 ACT GP
2869 NAPIER AVE, MACON 31204
MCMILLAN, E.C., JR. 06 ACT GS,FP
670 NEW ST, MACON 31201
MCMILLIAN, JAMES R. 27 ACT PD
HARBIN CLINIC, ROME 30161
MCMURRAY, ARTHUR A. 16 ACT GS
33 SW UPPER RIVERDALE RD, RIVERDALE 30274
MCNAIR, GEORGE 65 ACT AN
JD ARCHBOLD MEM HOSPITAL, THOMASVILLE 31792
MCNAIR, HAL 54 ACT FP
3623 J DEWEY GRAY CR, AUGUSTA 30909
MCNAIR, WILLIAM P. 57 ACT FP
115 SECOND ST S, SOPERTON 30457
MCNATT, EUGENE N. 42 ACT PTH
FAIRVIEW PARK HOSPITAL, DUBLIN 31021
MCNATT, JIM H. 17 ACT OPH
653 CHEROKEE ST, MARIETTA 30090
MCNAUGHTON, PHILIP Z. 11 ACT D
7805 WATERS AVE #9-A, SAVANNAH 31406
MCNEILL, A.A., JR. 46 ACT FP
PO BOX 389, CAMILLA 31730
MCPHEETERS, HAROLO L. 29 ACT P
1340 SPRING ST NW STE 400, ATLANTA 30309
MCPHERSON, JOHN H.T. 15 R GS
350 TALLASSEE FARM DR, ATHENS 30606
MCQUAIG, C. STEPHEN 02 ACT OPH
540-A WEST THOMAS, MILLEDGEVILLE 31061
MCRAE, ANDREW THOMAS 56 ACT GS
2704 NORTH OAK ST, VALDOSTA 31602
MCRAE, DONALD R., JR. 54 ACT GS
1256 MERRY ST, AUGUSTA 30904
MCREYNOLOS, B.A. 11 ACT GS
PO BOX 23089, SAVANNAH 31403
MCSWEENEY, MARJORIE B. 29 ACT DR
EMORY UNIV HOSP RADIOLOGY, ATLANTA 30322
MCWHIRTER, WILLIAM R. 47 ACT AN
5030 SEARS CT, COLUMBUS 31907
MEADERS, HENRY D. 17 ACT OBG
705 CAMPBELL HILL ST, MARIETTA 30060
MEADORS, JASON LAWRENCE 56 ACT R
2704-D NORTH OAK ST, VALDOSTA 31602
MEADOWS, CARTER LEE 25 ACT GS
PO BOX 879, SWAINSBORO 30401
MEADOWS, JAMES A., III 11 ACT IM
11706 MERCY BLVD #6, SAVANNAH 31406
MEADOWS, NOAH D., JR. 17 ACT IM
52 TOWER RD, MARIETTA 30060
MEDART, WILLIAM S., JR. 11 ACT FP
6409 ABERCORN ST, SAVANNAH 31405
MEDDERS, LARRY L. 15 ACT ORS
125 KING AVE, ATHENS 30610
MEDINA, LEONARDO H. 16 ACT U
217 UPPER RIVERDALE RD, RIVERDALE 30274
MEEHAN, PETER L. 29 ACT ORS
1001 JOHNSON FERRY RD NE, ATLANTA 30363

MEEKS, CALVIN STEWART, JR. 18 ACT FP
PO BOX 367 OCILLA RD, DOUGLAS 31533
MEEKS, WILLIAM H. 54 ACT NS
820 ST SEBASTIAN WAY, AUGUSTA 30910
MEES, OONALD E., JR. 29 ACT AN
1000 JOHNSON FERRY RD NE, ATLANTA 30342
MEGUIAR, RAMON V. 75 ACT OBG
PO BOX 1373, JESUP 31545
MEIER, MARK C. 23 ACT EM
2615 WELLINGTON DR, ALBANY 31707
MEIER, WALTER L. 17 ACT R
3865 STORY DR SW, MARIETTA 30060
MEINE, FREOERICK J. 47 ACT R
7352 LULLWATER RD, COLUMBUS 31904
MELTZER, HAROLO D. 29 ACT PTH
2736 FELTON DR, EAST POINT 30344
MELVIN, PERRY O. 36 ACT FP
110 HOSPITAL DR, WARNER ROBINS 31093
MENDELOFF, JOSEPH 29 S PTH
1670 CLAIRMONT RD NE, DECATUR 30033
MENDELSOHN, KEVIN B. 17 ACT OTO
1678 MULKEY RD STE F, AUSTELL 30001
MENOENHALL, CHARLES M. 23 ACT R,TR
PO BOX 63, ALBANY 31702
MENDEZ, RUBEN A. 17 ACT P,CHP
3985 SOUTH COBB DR, SMYRNA 30080
MENDEZ, SALVADOR A. 02 ACT P
1006 RIVERBEND DR, MILLEDGEVILLE 31061
MENENOEZ, JACK F. 06 ACT GS,ON
700 SPRING ST, MACON 31201
MERCER, CYNTHIA A. 15 ACT OBG
740 PRINCE AVE, ATHENS 30601
MEREDITH, TRAVIS A. 29 ACT OPH
1365 CLIFTON RD NE, ATLANTA 30322
MERLIN, HARVEY E. 16 ACT U
29 SW UPPER RIVERDALE RD, RIVERDALE 30274
MERMIN, MARGARET 29 ACT IM
484 MORELAND AVE STE 300, ATLANTA 30307
MERRILL, ARTHUR J. 29 ACT IM
35 COLLIER RD NW, ATLANTA 30309
MERRILL, ARTHUR J., JR. 29 ACT CD
1968 PEACHTREE RD NW, ATLANTA 30309
MERRILL, JONATHAN R. 35 ACT GS
117 ATHENS ST, HARTWELL 30643
MERRITT, BRAOLEY SAUNDERS 58 ACT IM
208 NORTH CUTHBERT ST, COLQUITT 31737
MERRITT, GEORGE W. 57 ACT FP
PO BOX 1187, VIDALIA 30474
MERSEREAU, JOHN B. 22 ACT EM,FP
560 LADONNA DR, DECATUR 30032
MERZ, CHRISTIAN L. 13 ACT OTO
PO BOX 907, LILBURN 30247
MESERVE, FRANCIS BRUCE 36 ACT GP
121 NORTH DAVIS DR, WARNER ROBINS 31093
MESSER, ALFRED A. 29 ACT P
801 DOUGLAS RD NE, ATLANTA 30342
METCALFE, JAMES K. 76 ACT CLP
PO BOX 1168, DALTON 30720
METTS, JAMES C., JR. 11 ACT IM
110 WEST GASTON ST, SAVANNAH 31401
MEYER, JOHN O. 29 ACT R
993-C JOHNSON FERRY RD NE, ATLANTA 30342
MEYER, ROGER A. 22 ACT MFS
1462 CLIFTON RD NE RM 214, ATLANTA 30345
MEYER, THOMAS P. 06 ACT CD
752 HEMLOCK ST, MACON 31201
MICHAELIDES, KYRIAKOS M. 17 ACT GE
1790 MULKEY RD STE 6-A, AUSTELL 30001
MICHIGAN, STEPHEN 11 ACT U
2515 HABERSHAM ST, SAVANNAH 31401
MICKEL, CAREY ALSTON, JR. 12 ACT GS
522 RHODES DR, ELBERTON 30635
MIDDENDORF, WAYNE F. 15 ACT IM,PUD
1010 PRINCE AVE #112, ATHENS 30606
MIDDLETON, FRANK F., III 23 ACT OBG
414 FIFTH AVE, ALBANY 31701
MIDDLETON, MILTON G. 65 ACT P
MENTAL HEALTH CENTER, THOMASVILLE 31792
MIHALOVITS, KARL S. 17 ACT P
3188 ATLANTA ST SE, SMYRNA 30080
MIKELL, JOEL E. 69 ACT R
PO BOX 170, THOMASTON 30286
MIKELL, JULIA L. 11 ACT N
207 EAST HALL ST, SAVANNAH 31401
MILES, MARY RYAN 10 ACT US
202 CROFT ST, CARROLLTON 30117
MILLAR, J. DONALD 29 S PH
1600 CLIFTON RD NE, ATLANTA 30333
MILLEOGE, ROBERT D. 29 ACT DR
1889 MERCEDES CT, ATLANTA 30345
MILLER, ABRAHAM 54 ACT OBG
1270 MERRY ST, AUGUSTA 30904
MILLER, CECIL L. 13 ACT FP
BUFORD MEDICAL CLINIC, BUFORD 30518
MILLER, CHESTER O. 29 ACT P
1970 CLIFF VALLEY WAY NE, ATLANTA 30329
MILLER, FRANK R. 65 ACT PD
509 GORDON AVE, THOMASVILLE 31792
MILLER, GARY M. 17 ACT PD,N
522 NORTH AVENUE, MARIETTA 30060
MILLER, GORDON C. 47 ACT CD
2300 MANCHESTER EXPY, COLUMBUS 31904
MILLER, J.M. 56 ACT OBG
2307 NORTH PATTERSON ST, VALDOSTA 31602
MILLER, JAMES A. 11 ACT PTH
PO BOX 9787, SAVANNAH 31402
MILLER, JAMES P. 47 ACT
1005 TALBOTTON RD, COLUMBUS 31995
MILLER, JAMES S. 15 ACT IM
700 OGLETHORPE AVE, ATHENS 30601
MILLER, JAMES W. 11 ACT CD
8 WHEELER ST, SAVANNAH 31405
MILLER, JOSEPH I. 29 ACT CD
25 PRESCOTT ST NE, ATLANTA 30308
MILLER, LILA BONNER 29 ACT P
768 JUNIPER ST NE, ATLANTA 30308
MILLER, PRESTON R. 29 ACT IM
960 JOHNSON FERRY RD NE, ATLANTA 30342
MILLER, ROBERT E. 75 ACT FP
PO BOX C, JESUP 31545
MILLER, ROBERT H. 30 ACT EM
PO BOX 1956, BRUNSWICK 31521
MILLER, S. JONES 68 ACT OBG
303 MEDICAL DR STE 403-405, LA GRANGE 30240
MILLER, WILLIAM A. 11 ACT R
PO BOX 23089, SAVANNAH 31403
MILLER, WILLIAM C., JR. 06 I&R GS
MEDICAL CENTER OF CENTRAL GA, MACON 31210
MILLS, MARVIN LEON 70 ACT IM
300 DOCTORS BLDG, FT OGLETHORPE 30742
MILSAP, JAMES H., JR. 29 ACT R
35 COLLIER RD NW STE 305, ATLANTA 30309
MIMS, GEORGE T., JR. 17 ACT IM
787 CAMPBELL HILL ST, MARIETTA 30060
MIMS, OSCAR M. 65 ACT IM
900 GORDON AVE, THOMASVILLE 31792
MINOR, B. OONALD 22 ACT R,NR
2256 SAGAMORE HILLS DR, DECATUR 30033
MINOR, H.W. 29 ACT IM
4665 PEACHTREE-DUNWOODY RD, ATLANTA 30342
MINOR, JAMES B. 29 ACT CD
960 JOHNSON FERRY RD NE, ATLANTA 30342
MIRATE, OONALD J. 56 ACT OPH
STE 207 DOCTORS BLDG, VALDOSTA 31602
MIRON, EDWARD J. 31 ACT FP
PO BOX 125, CALHOUN 30701
MIRSKY, ROBERT S. 29 ACT
1203 NOBLE FOREST DR, NORCROSS 30092
MITCHELL, ALEX R. 06 ACT PTH
PO BOX 6000, MACON 31208
MITCHELL, C. CRAIG 23 ACT IM,CD
PO BOX 1326, ALBANY 31702
MITCHELL, DOROTHY E. 29 ACT END,GYN
80 BUTLER ST SE, ATLANTA 30335
MITCHELL, FRANK B., JR. 30 ACT GS
83 MALLORY VILLAS, ST SIMONS IS 31522
MITCHELL, J.T. 68 ACT R
206 PARK AVE, LA GRANGE 30240
MITCHELL, JAMES K., JR. 29 ACT OTO
5675 PEACHTREE-DUNWOODY RD, ATLANTA 30342
MITCHELL, MARVIN A. 29 ACT GS
3250 HOWELL MILL RD, ATLANTA 30327
MITCHELL, MARVIN M. 17 ACT ORS
3910 AUSTELL RD, AUSTELL 30001
MITCHELL, OTIS C. 29 ACT OBG
189 MEDICAL WAY STE C, RIVERDALE 30274
MITCHELL, P. ROBERT 17 ACT OBG
833 CAMPBELL HILL ST ' 250, MARIETTA 30090
MITCHELL, RICHARD M. 29 ACT OBG
35 COLLIER RD STE 320, ATLANTA 30309
MITCHELL, W.C. 17 ACT FP
3040 ATLANTA ST SE, SMYRNA 30080
MITCHELL, WILLIAM E. 29 ACT GS
2377 WOODWARD WAY NE, ATLANTA 30305
MITCHELL, WILLIAM E., JR. 29 ACT GS
35 COLLIER RD NW, ATLANTA 30309
MITHANI, KAMRUDIN K. 06 I&R
784 SPRING ST, MACON 31201
MITTENTHAL, MARK J. 29 ACT
993-D JOHNSON FERRY RD #360, ATLANTA 30342
MIXON, GEORGE E. 54 ACT FP
640 CARLTON DR, AUGUSTA 30909
MIXSON, E. HARRY 56 ACT GP
DOCTORS BLDG, VALDOSTA 31602
MIXSON, JOYCE F., JR. 56 ACT OBG
105 DOCTORS BLDG, VALDOSTA 31602
MIZE, C. SHANNON 13 ACT FP
208 HUDSON ST, CUMMING 30130
MOBASSER, SHAPOUR 29 ACT OBG
960 JOHNSON FERRY RD NE, ATLANTA 30342
MODI, THOMAS A. 29 ACT OBG
993 JOHNSON FERRY RD NE, ATLANTA 30342
MOHAN, BH KRISHNA 16 ACT IM
6507 PROFESSIONAL PL, RIVERDALE 30274
MOKAL, ALBERT J. 29 ACT R
35 LINDEN AVE NE, ATLANTA 30309
MOLDENHAUER, C. CRAIG 29 ACT AN
1364 CLIFTON RD NE, ATLANTA 30322
MOLINARI, VINCENT G. 17 ACT OBG
3903 SOUTH COBB DR, SMYRNA 30080
MOLINARO, JOHN R. 54 ACT GE
820 ST SEBASTIAN WAY STE 7-B, AUGUSTA 30902
MOLKNER, KENNETH C. 29 ACT P
3400 PEACHTREE RD STE 1211, ATLANTA 30326
MOLNAR, EDMUND M. 47 ACT GS
101 DOCTORS BLDG, COLUMBUS 31901
MOLYNEAUX, E.W. 68 ACT FP
1550 DOCTORS DR STE 305, LA GRANGE 30240
MONETT, ROBERT A. 22 ACT FP
755 COLUMBIA DR STE 602, DECATUR 30030
MONFORT, JOHN M. 29 ACT IM
6 LARK RD, HILTON HEAD IS SC 29928
MONGAN, PATRICK F. 54 ACT FP
MEDICAL COLLEGE OF GEORGIA, AUGUSTA 30912
MONTERO, ENRIQUE 59 ACT AN
546 SOUTH EIGHTH ST, GRIFFIN 30223
MONTES, ISMAEL G. 58 ACT GS
PO BOX 114, COLQUITT 31737
MONTGOMERY, THOMAS A. 15 ACT GS
1010 PRINCE AVE, ATHENS 30606
MOON, ELLIOTT C. 22 ACT OBG
5 LAVISTA PERIMETER OFC PK, TUCKER 30084
MOONEY, ALFONSO J., III 08 ACT FP
PO BOX 508, STATESBORO 30458
MOORE, C.W.C. 27 ACT IM
304 EAST SECOND AVE, ROME 30161
MOORE, F. STEPHEN 34 ACT IM
660-F LANIER PARK DR, GAINESVILLE 30501

MOORE, G. RICHARD 29 ACT OBG
1311 CLEVELANO AVE ' 305, EAST POINT 30344
MOORE, HAYWOOO L. 30 R IM
123 ARTHUR MOORE OR, ST SIMONS IS 31522
MOORE, JOHN E. 29 ACT TS,CD
272 BOULEVARO NE, ATLANTA 30312
MOORE, PERRY 02 ACT R
BALOWIN CO HOSPITAL, MILLEDGEVILLE 31061
MOORE, VICTOR A. 54 ACT IM
UNIVERSITY HOSP, AUGUSTA 30902
MOORE, W.W., JR. 29 ACT NS
25 PRESCOTT ST NE STE 4439, ATLANTA 30308
MOOREHEAD, FRANKIE L. 29 A PD
75 PIEDMONT AVE NE STE 470, ATLANTA 30303
MOORES, RUSSELL R. 54 ACT IM
MEOICAL COLLEGE OF GEORGIA, AUGUSTA 30912
MOORHEAD, CHRISTIAN R. 29 ACT OBG
75 PIEDMONT AVE NE, ATLANTA 30303
MOORHEAD, JOSEPH H. 29 A OBG
75 PIEDMONT AVE NE, ATLANTA 30303
MOORMAN, LARRY R. 66 ACT OPH
1803 OLO OCILLA RD, TIFTON 31794
MOOSAJEE, RAZIUDIN Y. 36 ACT PD
1049 NORTH HOUSTON RO, WARNER ROBINS 31093
MORAN, MARTIN J. 29 ACT PO
993-F JOHNSON FERRY RO NE, ATLANTA 30342
MORAN, MICHAEL P. 47 I&R
PO BOX 951, COLUMBUS 31994
MOREE, LAMAR H. 23 ACT AN
2604 EAST OOUBLEGATE, ALBANY 31707
MORELAND, C.C. 71 ACT GP
WALTON CLINIC, MONROE 30655
MORELAND, STEVEN C. 29 ACT OBG
105 COLLIER RD NW STE 1080, ATLANTA 30309
MORELL, RENE A. 17 ACT OBG
3903 SOUTH COBB OR, SMYRNA 30080
MORENO, HUGO S. 29 ACT OBG
2739 FELTON DR, EAST POINT 30344
MORETZ, WILLIAM H. 54 ACT GS
TALMADGE MEMORIAL HOSPITAL, AUGUSTA 30912
MORGAN, DAVID L. 22 ACT PO
1901 CENTURY BLVD NE STE 20, ATLANTA 30345
MORGAN, FRANK E., JR. 22 ACT R
755 COLUMBIA DR STE 205, OECATUR 30030
MORGAN, HARVEY V. 11 ACT GP
1805 ABERCORN ST, SAVANNAH 31401
MORGAN, HORACE L. 29 R OM
345 CASTLERIDGE OR NE, ATLANTA 30342
MORGAN, JAMES C., III 68 ACT OPH
303 SMITH ST, LA GRANGE 30240
MORGAN, JAMES C., JR. 68 ACT OPH
PO BOX 590, WEST POINT 31833
MORGAN, JAMES W. 29 ACT U
490 PEACHTREE ST STE 578-C, ATLANTA 30308
MORGAN, MARY E. 54 ACT IM
VA HOSPITAL, AUGUSTA 30910
MORGAN, PHILIP E. 29 ACT OM
2000 NORTHEAST EXPY, NORCROSS 30071
MORGAN, ROBERT T. 66 ACT EM
PO BOX 672, ADEL 31620
MORGAN, TOBY S. 27 ACT OTO
107 JOHN MADDOX DR, ROME 30161
MORGAN, Z.V., JR. 22 ACT IM
495 WINN WAY 'B-220, OECATUR 30030
MORGANSTERN, STEVEN L. 29 ACT U
3280 HOWELL MILL RO, ATLANTA 30327
MORGENSTERN, JACK A. 06 ACT P,CHP
3500 RIVERSIOE DR, MACON 31209
MORK, VIRGINIA G. 29 I&R
GRAOY MEMORIAL HOSPITAL, ATLANTA 30303
MORLEY, ANDY P., JR. 22 ACT FP
755 COLUMBIA OR STE 333, DECATUR 30030
MORRIS, A.J. 57 ACT GS
PO BOX 1328, VIOALIA 30474
MORRIS, CLELL V. 15 ACT IM,N
2090 PRINCE AVE, ATHENS 30606
MORRIS, DOUGLAS C. 29 ACT IM
25 PRESCOTT ST NE, ATLANTA 30308
MORRIS, LARRY A. 34 ACT PD
650 BROAO ST SE, GAINESVILLE 30505
MORRIS, MICHAEL D. 06 ACT FP
1572 FOREST HILL RO, MACON 31210
MORRIS, STEVEN J. 29 ACT IM
25 PRESCOTT ST NE STE 5404, ATLANTA 30365
MORRIS, THOMAS W. 47 ACT FP
PO BOX 749, EATONTON 31024
MORRISON, JAMES P. 15 ACT PD
1010 PRINCE AVE, ATHENS 30606
MORRISON, JOSEPH V., JR. 11 ACT PD
4 MEDICAL ARTS CENTER, SAVANNAH 31405
MORRISON, WILLIAM N. 29 ACT U
340 BOULEVARD NE STE 409, ATLANTA 30312
MORRISSY, RAYMOND T. 29 ACT PD
1001 JOHNSON FERRY RO NE, ATLANTA 30363
MORROW, RICHARD C. 10 ACT U
GROOVER MEDICAL BLOG, CARROLLTON 30117
MORSE, CHESTER W. 22 ACT IM
711 CHURCH ST, DECATUR 30030
MORTON, BENJAMIN D., III 06 ACT PTH
777 HEMLOCK ST, MACON 31201
MORTON, JOHN B. 42 ACT IM
PO BOX 486, GRAY 31032
MORTON, ROBERT O. 19 ACT IM
717 SOUTH MAIN, MOULTRIE 31768
MORTON, WILLIAM J. 29 ACT U
4553 NORTH SHALLOWFORD RD, ATLANTA 30338
MORTON, WILLIAM J. 65 ACT FP
220 FIRST ST SE, CAIRO 31728
MOSELEY, THOMAS H. 56 ACT OBG
DOCTORS BLDG, VALOOSTA 31602
MOSELEY, THOMAS H., JR. 56 ACT OBG
2704 NORTH OAK ST, VALDOSTA 31602
MOSS, BENJAMIN F., JR. 54 ACT P
820 ST SEBASTIAN WAY STE 3-D, AUGUSTA 30902
MOSS, RICHARD N. 54 ACT FP
1417 PENDLETON RD, AUGUSTA 30904
MOSS, T.H., SR. 27 ACT OBG
409 SOUTH BROAO ST, ROME 30161
MOSS, THOMAS H., JR. 27 ACT FP
409 SOUTH BROAO ST, ROME 30161
MOTE, PAUL S. 54 ACT AN
MEDICAL COLLEGE OF GEORGIA, AUGUSTA 30912
MOUNA, YOUSSEF 54 ACT IM
1109 MEDICAL CENTER DR, AUGUSTA 30909
MOUSSAKHANI, JOSEPH 22 ACT OBG
497 WINN WAY STE A-115, DECATUR 30030
MOYE, BEN H. 56 ACT OPH
3024 NORTH PATTERSON ST, VALOOSTA 31602
MOYE, ROBERT J. 31 ACT GS
REDBUO RO, CALHOUN 30701
MOYER, LEROY N. 29 ACT OBG
1175 PEACHTREE ST NE, ATLANTA 30309
MUHANNA, SHAJIH 38 ACT CDS
150 MEDICAL WAY STE 3-1, RIVERDALE 30274
MULHERIN, C.S. 54 ACT GS
1527 GWINNETT ST, AUGUSTA 30904
MULHERIN, JOSEPH A. 11 ACT AN
711 EAST 44TH ST, SAVANNAH 31405
MULHERIN, JOSEPH L. 54 ACT GS
820 ST SEBASTIAN WAY STE 4-O, AUGUSTA 30901
MULHERIN, WILLIAM B. 15 ACT ORS
125 KING AVE, ATHENS 30601
MULKEY, A.P. 08 ACT GS
110 EAST COLLEGE AVE, MILLEN 30442
MULL, MICHAEL S. 17 ACT OBG
114 CHERRY ST STE F, MARIETTA 30060
MULLER, GERALD B. 65 ACT OBG
918 SOUTH BROAD ST, THOMASVILLE 31792
MULLINIKS, ROBERT C., JR. 17 ACT OBG
1790 MULKEY RD STE 5-A, AUSTELL 30001
MULLINS, SPENCER G. 17 ACT GS
805 CAMPBELL HILL ST, MARIETTA 30060
MULLINS, WILLIAM B. 54 ACT PTH
1402 WALTON WAY, AUGUSTA 30904
MUNDY, H. BRENT 10 ACT U
GROOVER MEDICAL BLDG, CARROLLTON 30117
MUNN, E.K. 47 ACT OBG
1112 JEANETTE AVE, COLUMBUS 31906
MUNNA, JOHN C. 29 ACT PS
3280 HOWELL MILL RO NW, ATLANTA 30327
MURDOCK, ROBERT N. 47 ACT FP
6309 CAPE COD OR, COLUMBUS 31904
MURPHEY, ALEX T. 54 ACT IM
820 ST SEBASTIAN WAY STE 7-A, AUGUSTA 30902
MURPHY, CHRISTINE H. 29 ACT R
1365 CLIFTON RD NE, ATLANTA 30322
MURPHY, HARVEY J. 11 ACT GS
5354 REYNOLOS ST STE 420, SAVANNAH 31405
MURPHY, MICHAEL J. 54 ACT OPH
1514 ANTHONY RO, AUGUSTA 30904
MURPHY, MICHAEL R. 29 ACT AN
1364 CLIFTON RO NE, ATLANTA 30322
MURPHY, RALPH A., JR. 29 ACT IM
35 COLLIER RO NW, ATLANTA 30309
MURRAY, OARRELL W. 17 ACT FP
1221 OLD POWOER SPRINGS RD, MABLETON 30059
MURRAY, OOUGLAS R. 29 ACT GS
1365 CLIFTON RO NE, ATLANTA 30322
MURRAY, H. HERNDON 29 ACT ORS
1938 PEACHTREE RD NW STE 710, ATLANTA 30309
MURRAY, HAMIL 34 ACT PTH
743 SPRING ST, GAINESVILLE 30505
MURRAY, WALTER A., JR. 13 ACT PO
3162 PIEDMONT RD NE, ATLANTA 30305
MUSARRA, E.A. 17 ACT FP
754 CHEROKEE ST, MARIETTA 30060
MUSARRA, E.A., II 17 ACT PS
833 CAMPBELL HILL ST ' 116, MARIETTA 30090
MUSE, A.D., JR. 15 ACT GS
740 PRINCE AVE, ATHENS 30601
MUSSER, A. WENDELL 29 S
VA MEDICAL CENTER, OECATUR 30033
MUSSER, ELLYN ZUNKER 17 ACT PO
2480 WINDY HILL RD STE 303, MARIETTA 30067
MYERS, ALLEN R. 29 ACT FP
1143 ALPHARETTA ST, ROSWELL 30075
MYERS, B. RHETT 36 ACT P
624 NEW ST, MACON 31201
MYERS, JAMES S. 76 ACT R
PO BOX 1285, OALTON 30720
MYERSON, GARY E. 29 ACT IM,RHU
960 JOHNSON FERRY RO, ATLANTA 30342

N

NADAL, GUILLERMO 22 ACT AN
755 COLUMBIA OR STE 413, OECATUR 30030
NAFFIS, DARIUS 29 ACT PD
993-O JOHNSON FERRY RO NE, ATLANTA 30342
NAGLER, STEPHEN M. 29 ACT GS,CRS
993-F JOHNSON FERRY RD, ATLANTA 30342
NAHAI, FOAD 29 ACT PS
25 PRESCOTT ST NE STE 5424, ATLANTA 30308
NAHMIAS, ANDRE J. 29 A PD
69 BUTLER ST SE, ATLANTA 30303
NAHMIAS, BRIGITTE 29 R IM
859 VISTAVIA CIR, DECATUR 30033
NAIB, Z.M. 22 ACT PTH
69 BUTLER ST SE, ATLANTA 30303
NAIOU, SARVESWAR I. 16 ACT ORS
6507 PROFESSIONAL PL STE C, RIVERDALE 30274
NAIDU, SUBRAMANYAM K. 16 ACT IM
PO BOX 1286, RIVERDALE 30274
NAIK, MADHAV V. 68 ACT GS
ENOCH CALLAWAY CANCER CTR, LA GRANGE 30240
NAIR, RADHAKRISHNAN V. 16 ACT ORS
4939 RIVERDALE RD, ATLANTA 30337

NAIR, VIMALA P. 29 ACT P
677 CHURCH ST, MARIETTA 30060
NAJAK, ZEBA O. 29 ACT PD
4575 NORTH SHALLOWFORD RD, ATLANTA 30338
NAJJAR, OMAR A. 22 ACT FP
755 COLUMBIA DR STE 333, DECATUR 30030
NAKANO, PHILLIP H. 29 I&R GS
1968 PEACHTREE RD NW, ATLANTA 30309
NAPOLI, VICTOR M. 29 ACT PTH
80 BUTLER ST SE, ATLANTA 30303
NARDELLI-OLKOWSKA, KRYSTYNA 22 ACT
2181 NORTHLAKE PKY, TUCKER 30084
NARDONE, AUGUST J. 22 R FP
99 BERKELEY RD, AVONDALE ESTATES 30002
NASH, O.A. 11 ACT OM
5720 COLONIAL DR, SAVANNAH 31406
NASH, MICHAEL LAWRENCE 11 ACT NEP,IM
PO BOX 15238, SAVANNAH 31416
NASSOUR, PAUL A. 70 ACT FP
TRI-COUNTY HOSPITAL, FT OGLETHORPE 30742
NATHAN, DANIEL E. 36 ACT FP
PO BOX 1179, FORT VALLEY 31030
NATION, THOMAS C. 18 ACT PTH
PO BOX 1248, DOUGLAS 31533
NATRAJAN, PUTHUGRAMAM K. 54 ACT OBG,END
903 - 15TH ST, AUGUSTA 30901
NAVARRO, ALFONSO V. 36 S IM
ROBINS AIR FORCE BASE, WARNER ROBINS 31098
NAZLI, MEHMET H. 17 ACT AN
1790 MULKEY RD STE 1, AUSTELL 30001
NEAL, JULE C., JR. 06 ACT OBG
380 HOSPITAL DR, MACON 31201
NEAL, RUTH E. 54 ACT R
1926 BYRNES RD, NORTH AUGUSTA SC 29841
NECHTMAN, CARL M. 54 ACT OTO
1511 ANTHONY RD, AUGUSTA 30904
NEELD, JOHN B. 29 ACT AN
3025 RIVER NORTH PKY, ATLANTA 30328
NEELY, F. LEVERING 29 ACT IM
35 COLLIER RD NW, ATLANTA 30309
NEGRI, FRANCISCO JOSE 32 ACT TS
8954 HOSPITAL DR, 115C, DOUGLASVILLE 30134
NEGRIN, NEIL J. 17 ACT ORS
3910 AUSTELL RD STE 101, AUSTELL 30001
NEIGHBORS, J.B., JR. 15 R IM
1010 PRINCE AVE, ATHENS 30601
NEILL, JAMES ROBERT 65 ACT IM
918 SOUTH BROAD ST, THOMASVILLE 31792
NELSON, ELLIS H. 54 ACT R
PO BOX 10106, AUGUSTA 30903
NELSON, FREO L., JR. 56 ACT R
PO BOX 308, NASHVILLE 31639
NELSON, GEORGE H. 54 ACT OBG
MEDICAL COLLEGE OF GEORGIA, AUGUSTA 30912
NELSON, HOMER S. 06 ACT OPH
PO BOX 956, MACON 31202
NELSON, MAYNARO 54 ACT GS
1502 ANTHONY RD, AUGUSTA 30904
NESBITT, ROBERT R., JR. 54 ACT GS
MEDICAL COLLEGE OF GEORGIA, AUGUSTA 30912
NETTLES, JOE L. 11 ACT ORS
PO BOX 22787, SAVANNAH 31405
NEUBERG, S. CHARLOTTE 06 ACT PD
2266 INGLESIDE AVE, MACON 31204
NEUFELD, JOCELYN R. 15 R AN
135 GATEWOOD PL, ATHENS 30606
NEVILLE, R.L., SR. 11 ACT GS
2115 BULL ST, SAVANNAH 31401
NEWBERRY, OAN C. 47 ACT AN
404 DOCTORS BLDG, COLUMBUS 31901
NEWLAND, HILLARY R. 15 ACT PTH
ATHENS GENERAL HOSP, ATHENS 30606
NEWMAN, HARVEY M. 34 ACT PD
650 BROAD ST SE, GAINESVILLE 30505
NEWMAN, PHILIP E. 29 I&R OPH
2555-A NEW HAVEN DR, ATLANTA 30345
NEWSOM, BRUCE C. 47 ACT GS
633-19TH ST, COLUMBUS 31901
NEWSOM, NEAL H. 29 ACT OBG
2045 PEACHTREE RD NE, ATLANTA 30309
NEWTON, JOHN S. 19 ACT OPH
PO BOX 663, MOULTRIE 31776
NEWTON, MAURY CLAIBORNE, JR. 17 ACT IM
787 CAMPBELL HILL ST, MARIETTA 30060
NEWTON, RALPH G., JR. 06 ACT U
718 FIRST ST, MACON 31201
NEWTON, W.R. 06 ACT PD
801 SPRING ST, MACON 31201
NEWTON, WALTER M., JR. 23 ACT PS
1909 ABERDEEN DR, ALBANY 31701
NEWTON, WILLIAM B. 71 ACT P,CHP
333 ALCOVA ST, MONROE 30655
NEWTON, ZACHARIAH B., III 29 ACT OBG
490 PEACHTREE ST STE 353-B, ATLANTA 30308
NEZHAT, CAMRAN 29 ACT OBG
5675 PEACHTREE-DUNWOODY RD, ATLANTA 30342
NICHOLAS, EDMUND M. 29 ACT U
3280 HOWELL MILL RD STE 107, ATLANTA 30329
NICHOLS, EVANS J. 17 ACT OBG
705 CAMPBELL HILL ST, MARIETTA 30060
NICHOLS, FENWICK T., JR. 11 ACT IM
PO BOX 22757, SAVANNAH 31403
NICHOLS, JOSEPH J. 29 ACT CRS
490 PEACHTREE ST NE, ATLANTA 30308
NICHOLS, POMEROY 54 ACT NS
820 ST SEBASTIAN WAY, AUGUSTA 30910
NICHOLS, W.H. 14 ACT FP
110 WALESKA RD, CANTON 30114
NICHOLSON, F. PETER 16 ACT U
29 SW UPPER RIVERDALE RD, RIVERDALE 30274
NICHOLSON, GEORGE T., MD FAAFP 33 ACT FP
PO BOX 147, CORNELIA 30531
NICHOLSON, W. LANIER 34 ACT FP
2 HOSPITAL ST, HIAWASSEE 30546
NICHOLSON, WILLIAM L. 30 ACT OTO
3228 SHRINE RD, BRUNSWICK 31520
NICKERSON, JOHN F. 29 ACT PTH
35 LINDEN AVE NE, ATLANTA 30308
NICOL, CHARLES F. 29 ACT N
315 BOULEVARD NE STE 224, ATLANTA 30312
NIELSON, CRAIG M. 23 ACT PUD,IM
1100 NORTH MADISON ST, ALBANY 31701
NIJEM, RICHARD J. 56 ACT IM
PO BOX 1086, VALDOSTA 31601
NIJEM, WILLIAM 56 ACT CD,IM
PO BOX 1086, VALDOSTA 31601
NILES, GEORGE A., JR. 29 ACT GYN
2045 PEACHTREE RD NE STE 415, ATLANTA 30309
NINCIC, ALEXANDER 29 ACT U
478 PEACHTREE ST STE 905-A, ATLANTA 30308
NINO, HOMERO F. 29 S R
1670 CLAIRMONT RD, DECATUR 30033
NIPPERT, PHILIP H. 29 ACT D
478 PEACHTREE ST NE, ATLANTA 30308
NIX, DILLARD L. 15 ACT OTO
1010 PRINCE AVE, ATHENS 30606
NIX, EDWARD O. 22 ACT P
1989 WILLIAMSBURG DR 'A, DECATUR 30033
NIXON, DANIEL W. 22 ACT ON
1365 CLIFTON RD NE, ATLANTA 30322
NODAL, RONALDO R. 22 ACT OBG
7 LAVISTA PERIMETER OFC PK, TUCKER 30084
NOLAN, THOMAS R. 29 ACT GS,CDS
1170 CLEVELAND AVE, EAST POINT 30344
NOLEN, JOHN HENRY, JR. 17 ACT OPH
653 CHEROKEE ST, MARIETTA 30060
NOLLER, STEPHEN A. 06 ACT CD
770 PINE ST STE 480, MACON 31201
NORMAN, LEWIS G., JR. 68 R GS
1101 THIRD AVE, WEST POINT 31833
NORMAN, MICHAEL 22 ACT N
370 WINN WAY STE 102, DECATUR 30030
NORTH, ALVIN W. 29 ACT OPH
2004 PEACHTREE RD NW, ATLANTA 30309
NORTHUP, JOHN D. 11 ACT IM,GE
12345 MERCY BLVD, SAVANNAH 31406
NORTON, R.F. 27 R OBG
514 COOPER DR, ROME 30161
NORWOOD, LYLE A. 47 ACT ORS
6262 HAMILTON RD, COLUMBUS 31904
NORWOOD, WILLIAM F. 29 ACT PD
105 COLLIER RD NW STE 4060, ATLANTA 30309
NOVEY, EDWARD S. 15 ACT N
2090 PRINCE AVE, ATHENS 30606
NUGENT, ELIZABETH W. 29 ACT PD
EMORY UNIVERSITY, ATLANTA 30322
NUGENT, JEFFREY T. 29 ACT ORS
105 COLLIER RD NW STE 5000, ATLANTA 30309
NUNEZ, WILLIAM O. 29 ACT AN
2760-B FELTON DR, EAST POINT 30344
NUTT, RICHARD L., JR. 30 ACT AN
PO BOX 1316, BRUNSWICK 31521
NUTT, RICHARD LAMAR 56 R AN
RTE 8 BOX 63, VALDOSTA 31601
NYSEWANDER, RICHARD W. 22 ACT P
2754 N DECATUR RD STE 102, DECATUR 30030

O

O'BARR, THOMAS B. 29 I&R
1075 BYRNWYCK TR, ATLANTA 30319
O'BRIEN, DAVID P. 29 ACT U
1365 CLIFTON RD NE, ATLANTA 30322
O'BRIEN, MARK S. 29 ACT NS
1365 CLIFTON RD NE, ATLANTA 30322
O'CONNELL, MICHAEL J. 72 ACT ORS
2507 ALICE ST, WAYCROSS 31501
O'DANIEL, J.F. 42 R FP
107 ROWE ST, DUBLIN 31021
O'HANLAN, KATHERINE A. 29 I&R OBG
2078 LENOX RD NE, ATLANTA 30324
O'NEAL, BUFORD L. 29 ACT OTO
173 PUTNAM CIR NE, ATLANTA 30342
O'NEAL, JOHN B., III 12 ACT GS
33 CHESTNUT ST, ELBERTON 30635
O'NEAL, PAMELA 29 ACT IM
1396 NORMANDY DR NE #1, ATLANTA 30306
O'NEAL, PHYLLIS J. 12 ACT GER
33 CHESTNUT ST, ELBERTON 30635
O'QUIN, WILLIAM P. 29 R FP
2100 PARKLAKE DR NE STE 11, ATLANTA 30345
O'QUINN, JAMES L. 54 ACT PTH
PO BOX 2406, AUGUSTA 30903
O'QUINN, MARY H. 54 ACT PTH
3651 WHEELER RD, AUGUSTA 30910
O'REAR, HARRY B. 54 ACT PD
MEDICAL COLLEGE OF GEORGIA, AUGUSTA 30912
O'SHAUGHNESSEY, W. JOHN, JR. 06 ACT IM
618 ORANGE ST, MACON 31201
OBRIEN, JOHN F. 22 ACT D
1276 MCCONNELL DR, DECATUR 30033
ODEN, LEWIS H., JR. 72 R GP
PO BOX 149, BLACKSHEAR 31516
ODOM, W.S. 47 ACT GP
422 1/2 NINTH ST, COLUMBUS 31901
OETTINGER, CARL W. 29 ACT IM,NEP
25 PRESCOTT ST #6426, ATLANTA 30308
OGBURN, CHARLES L., JR. 06 ACT IM
618 ORANGE ST, MACON 31210
OGLESBY, JAMES W. 23 ACT IM,EM
RTE 3 BOX 375-A, LEESBURG 31763
OGUZ, SADI 47 ACT P
PO BOX 12435, COLUMBUS 31995
OKEHI, OBI C. 06 ACT OBG
770 PINE ST STE 310, MACON 31201
OKEL, BENJAMIN B. 22 ACT IM
2193 NORTH DECATUR RD, DECATUR 30033

OLANSKY, ALAN J. 29 ACT D
401 WEST PEACHTREE ST NE, ATLANTA 30308
OLANSKY, DAVID C. 29 ACT D
401 WEST PEACHTREE ST NE, ATLANTA 30308
OLANSKY, MARIAN F. 29 R PD
1365 CLIFTON RD NE, ATLANTA 30322
OLANSKY, SIDNEY 29 ACT D
401 WEST PEACHTREE ST NE, ATLANTA 30308
OLDHAM, HARRY M., JR. 54 ACT OBG
2300 WRIGHTSBORO RD, AUGUSTA 30904
OLIVER, IZHAK 17 ACT IM,END
1001 THORNTON RD, LITHIA SPRINGS 30057
OLIVER, JOHN H. 54 ACT OBG
1501 ANTHONY RD, AUGUSTA 30910
OLIVER, ROBERT L. 11 ACT GS
RT 3 BOX 306-C, SAVANNAH 31406
OLIVER, ROBERT W., JR. 42 ACT GS
508 ACAOEMY AVE, OUBLIN 31021
OLKOWSKI, Z.L. 22 A R
1365 CLIFTON RD NE, ATLANTA 30322
OLLER, JOSEPH L. 54 ACT AN
812-13TH ST, AUGUSTA 30901
OLLINS, ROBERT J. 29 ACT IM
565 WEST PEACHTREE ST NE, ATLANTA 30308
OLNICK, HERBERT M. 06 R R
1700 PRESIOENTIAL WAY, W PALM BEACH 33401
OLSON, CLYDE L. 11 ACT OPH
2 JACKSON BLVD, SAVANNAH 31405
ONG, ANTONIO L. 62 ACT FP
PO BOX 764, HINESVILLE 31313
ONG, CECILIA B. 62 ACT PD
214 FRASER OR, HINESVILLE 31313
ORAN, ERDOGAN 17 ACT CD
4426 AUSTELL RD, AUSTELL 30001
ORDONEZ, CARLOS 29 ACT R
1170 CLEVELAND AVE, EAST POINT 30344
OROSZ, JUDY I. 54 ACT PO
1350 WALTON WAY, AUGUSTA 30910
ORR, A. STEPHENS 29 ACT OBG
490 PEACHTREE ST NE, ATLANTA 30308
ORR, DOUGLAS W. 29 ACT ON,HEM
993-O JOHNSON FERRY RD NE, ATLANTA 30342
ORR, JAMES B. 29 I&R
652 PARK LN, DECATUR 30033
ORR, WILLIAM W. 06 ACT PD
2009 VINEVILLE AVE, MACON 31204
ORTEGA, HERNANDO JOSE 29 ACT GS
2163 NORTHLAKE PKY STE 103-1, TUCKER 30084
OSBORNE, ELTON S., JR. 29 ACT PH
277 FAIRGROUNO ST SE, MARIETTA 30060
OSBORNE, W.W. 11 R OBG
PO BOX 14686, SAVANNAH 31406
OSHLAG, ABRAHAM M. 59 ACT IM
718 SOUTH EIGHTH ST, GRIFFIN 30223
OSMAN, MAGDY A. 11 ACT FP
5354 REYNOLOS ST, SAVANNAH 31405
OSMON, CARLOS A. 17 ACT IM
1790 MULKEY RO STE 4, AUSTELL 30001
OSTA, SALIM M. 30 ACT ON
280 REDFERN VILLAGE, ST SIMONS IS 31522
OSTEEN, CLARK L. 11 ACT AN
206 WEST BAY ST, SAVANNAH 31401
OSTER, CAROL H. 29 ACT FP
6701 ROSWELL RO NE, ATLANTA 30328
OTHMAN, MUFID A. 06 ACT IM,NEP
770 PINE ST STE 410, MACON 31201
OTIS, JOHN B. 29 ACT PTH
340 BOULEVARD NE, ATLANTA 30312
OTKEN, LUTHER B., JR. 54 ACT PTH
TALMADGE MEMORIAL HOSPITAL, AUGUSTA 30902
OTTS, JOHN C. 42 ACT FP
ERIN OFFICE PARK, OUBLIN 31021
OUZTS, HARVEY 15 ACT CO
700 OGLETHORPE AVE, ATHENS 30601
OWEN, RALPH G. 54 ACT OBG
1710 CENTRAL AVE, AUGUSTA 30904
OWENS, JOSEPH L. 30 ACT TS
3208 SHRINE RD, BRUNSWICK 31520
OWENS, ROGER D. 34 ACT IM
667 LANIER PARK DR NE, GAINESVILLE 30505
OWINGS, FRANCIS B. 29 ACT GS
478 PEACHTREE ST STE 717-A, ATLANTA 30308
OXFORD, WILLIAM M. 69 ACT GS
405 WEST MAIN ST, THOMASTON 30297

P

PACIFICI, JOSEPH 11 ACT GP
40 EAST 50TH ST, SAVANNAH 31405
PACKER, ROBERT M., III 72 ACT IM
PO BOX 899, WAYCROSS 31501
PACKER, ROBERT M., JR. 72 ACT IM
PO BOX 899, WAYCROSS 31501
PAGE, CROCKETT H. 23 S GP
333 MOCK ROAD APT 101, ALBANY 31705
PAGE, JOHN A. 06 ACT OPH
800 FIRST ST, MACON 31201
PAKALNIS, VYTAUTAS A. 54 ACT OPH
MEDICAL COLLEGE OF GEORGIA, AUGUSTA 30912
PALAY, BERNARD H. 29 ACT IM,AL
1372 PEACHTREE ST NE, ATLANTA 30309
PALMER, E. CAPERS, JR. 68 ACT PTH
819-D MONA LN, LA GRANGE 30240
PALMER, FRED L. 17 ACT R
3865 STORY OR, MARIETTA 30060
PALMER, JACK R. 15 ACT FP
1010 PRINCE AVE E, ATHENS 30601
PALMER, JAMES D. 29 ACT IM
970 MARTIN L KING JR DR, ATLANTA 30314
PALMER, SUZANNE J. 02 ACT OBG
PO BOX 489, MILLEDGEVILLE 31061
PANNELL, WILLIAM P. 26 ACT GS
PO BOX 1016, CORDELE 31015
PARHAM, ROBERT E. 17 ACT N
833 CAMPBELL HILL ST ' 430, MARIETTA 30090
PARIS, RAY BENJAMIN 47 ACT FP
2100 NORTH AVE, COLUMBUS 31904
PARISH, HAVNER H., JR. 23 ACT U
802 NORTH JEFFERSON ST, ALBANY 31708
PARK, GEORGE T. 48 ACT IM
4186 MILL ST NE, COVINGTON 30209
PARK, IH KOO 70 ACT GS
200 OOCTORS BLDG, FT OGLETHORPE 30742
PARK, JUNESEOK 79 ACT GS
310 NORTH WESTBERRY ST, SYLVESTER 31791
PARKE, JAMES G. 30 ACT GS
613 OLO PLANTATION, JEKYLL IS 31520
PARKER, FRANK M. 36 ACT OBG
105 BRIARCLIFF RD, WARNER ROBINS 31093
PARKER, J. LEE 49 ACT FP
PO BOX 179, GREENSBORO 30642
PARKER, WILEY A. 29 ACT OTO
5669 PEACHTREE-OUNWOOOY RD, ATLANTA 30342
PARKINSON, ALEXANDER T. 22 ACT PTH
450 NORTH CANOLER ST, OECATUR 30030
PARKS, JAMES F. 34 ACT IM
667 LANIER PARK DR NE, GAINESVILLE 30505
PARKS, JOSEPH W., JR. 20 ACT FP
PO BOX 609, NEWNAN 30264
PARNELL, R. PARKS, JR. 29 ACT FP
4384 OAKOALE RD, SMYRNA 30080
PARRISH, JOE E. 10 ACT OBG
115 HOSPITAL OR, CARROLLTON 30117
PARRISH, ROBERT A., JR. 54 ACT GS
TALMADGE MEMORIAL HOSPITAL, AUGUSTA 30912
PARROTT, FRANK H. 23 ACT IM,PUO
806 FOURTEENTH AVE, ALBANY 31701
PARROTT, JESSE LYLE 56 ACT FP
204 EAST LAWSON ST STE 102, HAHIRA 31632
PARROTT, THOMAS S. 29 ACT U
993 JOHNSON FERRY RD NE, ATLANTA 30342
PARSONS, RICHARD C. 22 ACT OTO
755 COLUMBIA DR STE 720, DECATUR 30030
PARUNGAO, ROMULO L. 48 ACT GS,ABS
1315 MILSTEAO RD, CONYERS 30207
PASCHAL, J. DEAN 23 ACT PD
910 NORTH JEFFERSON ST, ALBANY 31701
PASCHAL, THOMAS C. 23 ACT PD
910 NORTH JEFFERSON ST, ALBANY 31701
PATCH, DAVID W. 60 ACT ORS
PO BOX 609, TOCCOA 30577
PATEL, ARVIND M. 18 ACT U
PO BOX 1018, DOUGLAS 31533
PATEL, BHARAT J. 61 ACT U
629 EAST FORSYTH ST, AMERICUS 31709
PATEL, BHARATKUMAR S. 01 ACT IM
210 EAST TOLLISON ST, BAXLEY 31513
PATEL, BIPIN 47 ACT IM,PUD
2300 MANCHESTER EXPY, COLUMBUS 31904
PATEL, DILIP T. 53 ACT IM
PO BOX 753, OAWSON 31742
PATEL, DILIPKUMAR R. 27 ACT PD
316 WEST TENTH ST, ROME 30161
PATEL, HASMUKH R. 76 ACT IM,GE
1217 MEMORIAL DR STE 2, OALTON 30720
PATEL, KANTILAL L. 42 ACT IM
106 ROWE ST, OUBLIN 31021
PATEL, MAHENDRA M. 60 ACT R
800 EAST OOYLE ST, TOCCOA 30577
PATEL, MANHARBHAI N. 59 ACT GS
610 SOUTH EIGHTH ST, GRIFFIN 30223
PATEL, NINNA B. 61 ACT OTO
PO BOX 805, AMERICUS 31709
PATEL, PANKAJ T. 42 S R
VA MEOICAL CENTER, OUBLIN 31021
PATEL, SUMANTKUMAR 59 ACT IM
691 SOUTH EIGHTH ST, GRIFFIN 30223
PATEL, THAKOR B. 17 ACT AN
BOX 517, AUSTELL 30001
PATRACHAI, CHAVALIT C.P. 29 ACT
1325 PEACHTREE ST APT 901, ATLANTA 30309
PATRICK, E.V. 10 ACT IM
624 DIXIE ST, CARROLLTON 30117
PATRICK, JOHN W. 69 ACT R
131 CHEROKEE RO, THOMASTON 30286
PATTERSON, GEORGE W. 50 ACT FP
717 GRIFFIN ST, EASTMAN 31023
PATTERSON, H. SCOTT 29 ACT P
3280 HOWELL MILL RD NW, ATLANTA 30327
PATTERSON, JOSEPH H. 29 ACT PD
1405 CLIFTON RO NE, ATLANTA 30322
PATTERSON, MCLEOD 47 ACT IM
1612 ELMWOOD OR, COLUMBUS 31906
PATTERSON, WILLIAM C. 17 R GS
3991 RIOGE RO SE, SMYRNA 30080
PATTERSON, WILLIAM O., JR 47 ACT P
711 CENTER ST, COLUMBUS 31901
PATTISON, E. MANSELL 54 ACT P
MEDICAL COLLEGE OF GEORGIA, AUGUSTA 30912
PATTON, HENRY M. 48 ACT IM
4186 MILL ST NE, COVINGTON 30209
PATTON, JOHN W. 29 ACT AN
PO BOX 28637, ATLANTA 30358
PATTON, MARY L. 06 ACT IM
800 FIRST ST STE 330, MACON 31201
PATTON, MAURICE G. 54 ACT PH
822 WINDSOR CT, AUGUSTA 30909
PATTON, ROBERT M. 47 ACT CO
4403 HOLLY AVE, COLUMBUS 31904
PATTON, SAMUEL E. 06 ACT IM
2923 GENERAL LEE RD, MACON 31204
PAULK, J.R. 19 R OPH
FAIRVIEW DR, MOULTRIE 31768
PAULLIN, WILLIAM L., JR. 29 ACT IM
35 COLLIER RO NW, ATLANTA 30309
PAULY, ROBERT P. 60 ACT GS
PO BOX 609, TOCCOA 30577

PAUSA, SERGIO G. 17 ACT GS
5367 GORDON RD EXT, MABLETON 30059
PAYNE, DOLFORD F., JR. 29 ACT GS
300 BOULEVARD NE, ATLANTA 30312
PAYNE, F. EDWARD, JR. 54 ACT FP
MEDICAL COLLEGE OF GEORGIA, AUGUSTA 30912
PAYNE, JOHN F. 65 ACT ORS
106 EUCLID DR, THOMASVILLE 31792
PAYNE, NETTLETON S. 29 ACT NS
993-F JOHNSON FERRY RD, ATLANTA 30342
PAYNE, PAUL J. 17 ACT ORS
652 CHURCH ST, MARIETTA 30060
PAYNE, PETER M. 29 ACT OBG
993-C JOHNSON FERRY RD NE, ATLANTA 30342
PAYNE, R.F. 54 ACT PH
3404 WALTON WAY EXT, AUGUSTA 30902
PAYNE, ROBERT A. 15 ACT U
195 KING AVE, ATHENS 30601
PAYNE, WOODROW W. 30 ACT U
3104 SHRINE RD, BRUNSWICK 31520
PAYTON, JOHN A. 60 ACT FP
800 E DOYLE ST, TOCCOA 30577
PEACOCK, LAMAR B. 29 ACT IM
478 PEACHTREE ST NE, ATLANTA 30308
PEACOCK, RAY L., JR. 34 ACT PD
274 ENOTA DR NE, GAINESVILLE 30505
PEARCE, T. ELDER, JR. 29 ACT GS
960 JOHNSON FERRY RD NE, ATLANTA 30342
PECHAL, FRANK D. 06 ACT GP
PO BOX 204, IRWINTON 31042
PEDERSON, ROBERT A. 65 ACT
704 SOUTH BROAD ST, THOMASVILLE 31792
PEEL, JESSE ROBERT 17 ACT P
3188 ATLANTA ST SE, SMYRNA 30080
PEIKEN, ALAN S. 47 ACT IM
500 - 18TH ST, COLUMBUS 31901
PEIRCE, KENNETH E. 47 ACT A,PDA
MEDICAL ARTS BLDG, COLUMBUS 31901
PELTZ, ROSEMONDE S. 22 ACT IM
2054-P LAWRENCEVILLE HWY, DECATUR 30033
PENA, LEOPOLD I. 17 ACT GS
3812 AUSTELL RD, MARIETTA 30060
PENCE, ROBERT L. 08 ACT GP
PO BOX 538, METTER 30439
PENDERGRAST, WILLIAM J. 29 ACT GS
478 PEACHTREE ST NE, ATLANTA 30308
PENDERGRAST, WILLIAM J., JR. 29 ACT PS
993 JOHNSON FERRY RD NE, ATLANTA 30342
PENG, VINCENT 16 ACT D
155 MEDICAL WAY, RIVERDALE 30274
PENNINGTON, CLAUDE L. 06 ACT OTO
800 FIRST ST, MACON 31201
PENNINGTON, E. EARL 29 ACT CRS
960 JOHNSON FERRY RD NE, ATLANTA 30342
PENNINGTON, JOHN A. 17 ACT AN
3112 BUNKER HILL DR, MARIETTA 30060
PENNINGTON, WEEMS RUFUS, JR. 54 ACT IM
820 ST SEBASTIAN WAY STE 2-A, AUGUSTA 30902
PENTECOST, MARK P. 29 ACT OBG
35 COLLIER RD NW, ATLANTA 30309
PEPIN, HENRY S. 65 ACT FP
602 EAST SEIXAS ST, THOMASVILLE 31792
PER-LEE, JOHN H. 29 ACT OTO,OT
EMORY UNIVERSITY CLINIC, ATLANTA 30322
PERDUE, GARLAND D., JR. 29 ACT GS
EMORY UNIVERSITY CLINIC, ATLANTA 30322
PEREZ, A.R. 29 ACT CDS
1311 CLEVELAND AVE, EAST POINT 30344
PEREZ, JUAN A. 02 ACT P
175 FORT WILKINSON RD, MILLEDGEVILLE 31061
PERKINS, DAVID 06 I&R FP
MEDICAL CENTER OF CENTRAL GA, MACON 31208
PERKINS, G.E., II 27 ACT PUD
5 CRESTWOOD DR, ROME 30161
PERKINS, H.R. 54 ACT OTO
4901 VAN CISE RD, ALBANY 31707
PERKINS, J. MORRIS 29 ACT P
3400 PEACHTREE RD NE STE 905, ATLANTA 30326
PERKINS, JACK B. 22 ACT AN
755 COLUMBIA DR STE 413, DECATUR 30030
PERKINSON, NEIL G. 29 ACT ND
5669 PEACHTREE-DUNWOODY RD, ATLANTA 30342
PERLING, DAVID S. 29 ACT IM
4536 CHAMBLEE-DUNWOODY #141, ATLANTA 30338
PERLSTEIN, SUSAN S. 29 ACT P
3400 PEACHTREE RD NE, ATLANTA 30326
PERROW, G.H. 14 ACT FP
201 EAST SPRING ST, JASPER 30143
PERRY, BYRON L. 17 ACT OTO,PS
833 CAMPBELL HILL ST ' 115, MARIETTA 30090
PERRY, SAMUEL W. 29 ACT PD
2820 OCEAN SHORE BL, ORMAND BEACH FL 32074
PERSALL, JOHN T. 54 ACT OBG
PO BOX 3584, AUGUSTA 30904
PESKIN, HERMAN 54 ACT IM
820 ST SEBASTIAN WAY STE 7-A, AUGUSTA 30902
PESKOE, STANLEY T. 06 ACT NEP,IM
BACONSFIELD OFFICE PARK, MACON 31201
PESZCZYNSKI, MIECZYSLAW 29 ACT PM
1920 BRECKENRIDGE DR NE, ATLANTA 30329
PETERS, HANS J. 47 ACT PTH
PO BOX 7000, COLUMBUS 31995
PETERS, JAMES S., JR.MD 29 ACT R
4513 CLUB CIR NE, ATLANTA 30319
PETERS, MARGARET P. 29 S AN
1670 CLAIRMONT RD NE, DECATUR 30033
PETERSON, DAVID A. 47 ACT IM,NEP
2300 MANCHESTER EXPY, COLUMBUS 31904
PETKOVICH, MILA 11 ACT PTH
13104 STILLWOOD RD, SAVANNAH 31406
PETREK, JEANNE A. 29 ACT GS
25 PRESCOTT ST NE, ATLANTA 30308
PETRY, GARY LYNN 13 ACT OM
367 BROOKSHIRE DR, LILBURN 30247
PETWAY, JAMES M. 54 I&R IM
28 CAMELLIA CIR, NEWNAN 30263
PFISTER, WILLIAM C. 66 ACT PTH
PO BOX 747, TIFTON 31793
PHELPS, PAUL R., SR. 06 ACT GS
770 PINE ST STE 330, MACON 31201
PHILBRICK, THOMAS H. 11 ACT R
311 EAST HALL ST, SAVANNAH 31401
PHILLIPS, A.M., JR. 06 ACT ORS
380 HOSPITAL DR, MACON 31201
PHILLIPS, ANDRO P. 11 ACT GP
323 EAST JONES ST, SAVANNAH 31401
PHILLIPS, CAROL ANN 54 ACT P
VA MEDICAL CENTER, AUGUSTA 30910
PHILLIPS, JAMES E. 06 ACT PTH
4946 BRITTANY DR, MACON 31204
PHILLIPS, JOE M., JR. 17 ACT OBG
180 CHEROKEE ST, MARIETTA 30060
PHILLIPS, ROBERT L. 75 ACT FP
PO BOX 937, JESUP 31545
PHILLIPS, ROGSBERT F. 29 ACT GS
20 LINDEN AVE, ATLANTA 30308
PHILLIPS, THOMAS W. 29 ACT TR
25 PRESCOTT ST, ATLANTA 30365
PHILLIPS, WENDELL E. 29 ACT OBG
11050 CRABAPPLE RD, ROSWELL 30075
PHRYDAS, IRENE A. 29 ACT P
3400 PEACHTREE RD NE, ATLANTA 30326
PHURROUGH, STEVE E. 07 S FP
75 SOUTHSIDE CHURCH ST, ELLIJAY 30540
PIATT, EDWARD D. 11 ACT R
9 MEDICAL ARTS CENTER, SAVANNAH 31405
PICKENS, JAMES C. 60 ACT OBG
800 EAST DOYLE ST, TOCCOA 30577
PICKFORD, LARRY BRUCE 13 ACT OTO
3400 MCCLURE BR RD, DULUTH 30136
PICKFORD, MICHAEL J. 13 I&R
3924 PLEASANT SHADE DR, DORAVILLE 30340
PIEDRAHITA, PABLO 48 ACT GS
2111 FLAT SHOALS RD, CONYERS 30208
PIERCE, MART T. 30 ACT FP
PO BOX 1003, BRUNSWICK 31520
PIERZCHAJLO, RICHARD P.J. 79 ACT FP
BOX 7010, TIFTON 31794
PIHL, B. ALFRED 22 ACT PS
1462 MONTREAL RD STE 411, TUCKER 30084
PIKE, BENJAMIN F. 47 ACT IM
2300 MANCHESTER EXPY, COLUMBUS 31904
PIKE, BENJAMIN L. 11 ACT IM
32 MEDICAL ARTS CENTER, SAVANNAH 31405
PILCHER, B. LAMAR 36 ACT R
PO BOX 2886, WARNER ROBINS 31093
PILCHER, JAMES WRIGHT, JR. 76 ACT IM
1203 MEMORIAL DR, DALTON 30720
PILON, ROBERT N. 15 ACT AN
111 WHIPPOORWILL PL, ATHENS 30605
PINE, JEFFREY R. 29 ACT PUD
1365 CLIFTON RD NE, ATLANTA 30332
PINERO, DIONISIO A., JR. 02 ACT PTH
PO BOX 1067, MILLEDGEVILLE 31061
PINSON, HARRY D. 54 ACT GS
ONE BRANSFORD PL, AUGUSTA 30904
PIRKLE, CECIL H. 29 ACT GS
1311 CLEVELAND AVE, EAST POINT 30344
PIRKLE, QUENTIN R., JR. 29 ACT IM
105 COLLIER RD NW STE 2070, ATLANTA 30309
PIRKLE, QUENTIN, SR. 22 ACT FP
BOX 10007, ATLANTA 30319
PIRKLE, T.N. 26 ACT R
212 GORDON ST UNIT 7, LA GRANGE 30240
PIROZZI, DONALD J. 29 ACT D
105 COLLIER RD NW STE 2060, ATLANTA 30367
PITTARD, M.D. 60 ACT FP
800 EAST DOYLE ST, TOCCOA 30577
PITTMAN, CARL S. 66 ACT FP
820 TIFT AVE, TIFTON 31794
PITTMAN, CARL S., JR. 66 ACT FP
820 TIFT AVE, TIFTON 31794
PITTMAN, FRANK S., III 29 ACT P
960 JOHNSON FERRY RD NE, ATLANTA 30342
PITTMAN, HOUSTON H. 27 ACT NS
HARBIN CLINIC, ROME 30161
PITTS, STEPHEN ROY 29 I&R IM
2537 ECHO DR NE, ATLANTA 30345
PIYASENA, HARRY G. 16 ACT IM
29 SW UPPER RIVERDALE RD, RIVERDALE 30274
PLANK, IRVIN E. 31 ACT AN,OBG
PO BOX 619, RESACA 30735
PLANZ, EDWARD J. 29 ACT CDS,TS
5669 PEACHTREE-DUNWOODY RD, ATLANTA 30342
PLAUCHE', WADE E. 68 ACT R
210 BATTLE ST, LA GRANGE 30240
PLAXICO, DAVID T. 06 ACT A,PDA
2327 INGLESIDE AVE, MACON 31204
PLEMONS, MICHAEL R. 16 ACT DR
PO BOX 699, RIVERDALE 30274
PLUMMER, ALAN 29 ACT IM
1365 CLIFTON RD NE, ATLANTA 30322
POBLETE, LETICIA 01 ACT GP
PO BOX 387, BAXLEY 31513
POBLETE, ROGELIO C. 01 ACT GP
PO BOX 387, BAXLEY 31513
PODOBNIKAR, MICHAEL F. 38 ACT GS
PO BOX 335, STOCKBRIDGE 30281
POEHLMAN, JOHN HOWARD 76 ACT IM
1436 BROADRICK DR, DALTON 30720
POGUE, ROBERT H. 29 ACT P
2151 PEACHFORD RD, ATLANTA 30338
POLHILL, JAMES B. 39 ACT FP
JEFFERSON HOSPITAL, LOUISVILLE 30434
POLIAKOFF, SAMUEL R. 29 ACT OBG
105 COLLIER RD NW STE 3050, ATLANTA 30309
POLLARD, ZANE F. 29 ACT PD,OPH
2004 PEACHTREE RD NW, ATLANTA 30309

POLLOCK, C. EUGENE 78 ACT GS
123 GORDON ST, WASHINGTON 30673
POLLOCK, JOHN EDWARD, JR. 78 ACT FP
123 GORDON ST, WASHINGTON 30673
POMERANCE, ALAN J. 22 ACT OBG
1462 MONTREAL RD STE 412, TUCKER 30084
POMEROY, W.L. 72 ACT GS
1421 ST MARYS DR 40970-A, WAYCROSS 31501
POMEROY, WILLIAM L., JR. 72 ACT IM
PO BOX 1889, WAYCROSS 31501
PONCE DE LEON, A.I. 29 ACT P
1970 CLIFF VALLEY WAY NE, ATLANTA 30329
POOL, LELAND L. 34 ACT AN
743 SPRING ST, GAINESVILLE 30505
POOL, WINFORD H., JR. 54 ACT R
TALMADGE MEMORIAL HOSPITAL, AUGUSTA 30912
POOLE, ROBERT NEIL 29 ACT PD
5675 PEACHTREE-DUNWOODY RD, ATLANTA 30342
POOLE, SAMUEL O. 34 ACT IM
710 BROAD ST SE, GAINESVILLE 30501
POON, GLEN S.H. 12 ACT FP
33 CHESTNUT ST, ELBERTON 30635
POPE, EUGENE J. 17 ACT CD
1001 THORNTON RD, L07, LITHIA SPRINGS 30057
POPE, JAMES CHANDLER 10 ACT CDS
619 DIXIE ST, CARROLLTON 30117
POPE, JAMES TERRELL 06 ACT OBG
380 HOSPITAL DR, MACON 31201
POPE, ROY, JR. 70 ACT FP
PO BOX 108, CHICKAMAUGA 30707
PORQUEZ, JOSE M.H. 71 ACT GS
PO BOX 191, MONROE 30655
PORTER, HARRY, JR. 17 ACT P
2700 CUMBERLAND PKY STE 320, ATLANTA 30339
PORTER, JERRY O. 29 ACT PTH
5665 PEACHTREE-DUNWOODY RD, ATLANTA 30342
PORTER, JOHN E. 11 ACT GP
6605 ABERCORN ST, SAVANNAH 31405
PORTER, MAC W. 22 ACT FP,OM
2100 PARKLAKE DR NE, ATLANTA 30345
PORUBSKY, EDWARD S. 54 ACT OTO
MEDICAL COLLEGE OF GEORGIA, AUGUSTA 30912
POTITONG, BANLU 69 ACT IM
PO BOX 752, THOMASTON 30286
POU, LEO H., JR. 29 ACT AN
2760-B FELTON DR, EAST POINT 30344
POULOS, PHILLIP R. 23 ACT IM
1700 EAST BROAD AVE, ALBANY 31705
POUND, EDWIN C., JR. 29 ACT PS
993 JOHNSON FERRY RD NE, ATLANTA 30342
POUNO, WILLIAM E. 06 ACT FP
670 NEW ST, MACON 31201
POWELL, BARBARA A. 54 ACT OBG
1505 ANTHONY RD, AUGUSTA 30904
POWELL, F.C. 22 ACT IM
200 SWANTON WAY STE 300, DECATUR 30030
POWELL, JACK H., JR. 20 ACT GS
PO BOX 609, NEWNAN 30263
POWELL, JOHN L. 15 ACT GYN
740 PRINCE AVE, ATHENS 30601
POWELL, MATTHEW J.G. 06 ACT FP
558 TAYLOR CT, MACON 31204
POWELL, MICHAEL F. 44 ACT IM
604 WARE ST, THOMSON 30824
POWELL, RALPH W. 22 ACT ON
1365 CLIFTON RD NE, ATLANTA 30322
POWERS, LEANDER K. 11 ACT GP
29 EAST JONES ST, SAVANNAH 31401
POWERS, ROBERT W. 29 ACT
105 COLLIER RD NW, ATLANTA 30309
PRADA, OSCAR 42 ACT FP
204 BROOKWOOD DR, DUBLIN 31021
PRADHAN, MEOHA A. 42 ACT AN
DUBLIN VA MEDICAL CENTER, DUBLIN 31021
PRATER, R. BURT, JR. 22 ACT FP
4553 NORTH SHALLOWFORD RD, ATLANTA 30338
PRATHER, STUART H., JR. 54 ACT R
3623 J DEWEY GRAY CR, AUGUSTA 30909
PRATT, FRANK G., JR. 27 ACT P
HARBIN CLINIC, ROME 30161
PRATT, SUZANNE 27 ACT OBG
909 NORTH FIFTH AVE, ROME 30161
PREAS, STEPHEN 29 A P
1970 CLIFF VALLEY WAY NE, ATLANTA 30329
PRICE, JOHN W. 17 ACT FP
1230 JOHNSON FERRY RD, MARIETTA 30067
PRICE, LAWRENCE W. 10 ACT FP
611 NORTH AVE, VILLA RICA 30180
PRICE, NORMA A. 29 ACT IM
993-D JOHNSON FERRY RD NE, ATLANTA 30342
PRICE, QUENTIN 42 ACT FP
205 WEST GAINES ST, DUBLIN 31021
PRICE, VIRGINIA H. 10 ACT FP
611 NORTH AVE, VILLA RICA 30180
PRIM, GARY J. 06 ACT AN
1860 FLINTWOOD DR, MACON 31201
PRINCE, ALAN D. 17 ACT N
522 NORTH AVE, MARIETTA 30060
PRINCE, RONALD B. 48 ACT IM
4140 TATE ST, COVINGTON 30209
PRINCE, RUSSELL B. 22 ACT P
1970 CLIFF VALLEY WAY NE, ATLANTA 30329
PRINE, JOE R. 42 ACT OTO
KELLAM RD, DUBLIN 31021
PRINTZ, DON W. 22 ACT D
4303 LAVISTA RD, TUCKER 30084
PRISANT, LOUIS M. 54 ACT IM,CD
MEDICAL COLLEGE OF GEORGIA, AUGUSTA 30912
PRITCHETT, JOHN H., JR. 10 ACT US
405 ALABAMA AVE, BREMEN 30110
PRITZKER, MARTIN S. 11 ACT D
712 EAST 70TH ST, SAVANNAH 31405
PROCTOR, ROBERT F. 34 ACT IM
660-I LANIER PARK DR NE, GAINESVILLE 30505
PRUCE, ARTHUR 29 ACT PM
495 WOODWARD WAY NW, ATLANTA 30308
PRUCE, MARTA 29 ACT P
480 BROOKFIELD DR NE, ATLANTA 30342
PRUETT, JAMES E. 22 ACT OTO
465 WINN WAY STE 221, DECATUR 30030
PRUITT, ALBERT W. 54 ACT PD
MEDICAL COLLEGE OF GEORGIA, AUGUSTA 30912
PRYOR, CAROL G. 54 ACT OBG
1500 JOHNS RD, AUGUSTA 30904
PULIOO, QUINTIN M. 56 ACT GS
101 WOODROW WILSON DR, VALDOSTA 31602
PUMPELLY, ROBERT A. 75 ACT FP
166 MEMORIAL DR, JESUP 31545
PURCELL, BILL 31 ACT FP
MEDICAL ARTS CENTER, CALHOUN 30701
PURCELL, DENT W. 11 ACT TR
PO BOX 7706, GARDEN CITY 31418
PURDOM, E. STEPHEN 47 ACT IM
1005 TALBOTTON RD, COLUMBUS 31904
PURI, RAM K., MD 02 ACT PUD
1836 TIMBERLANE CT, MILLEDGEVILLE 31061
PURKS, W. WARREN, JR. 47 ACT IM
ST FRANCIS MEDICAL PARK, COLUMBUS 31904
PURSER, ALVIN D. 75 ACT FP
PO BOX 937, JESUP 31545
PURSLEY, NORMAN B. 54 ACT OS
GEORGIA TRAINING SCHOOL, GRACEWOOD 30812
PURVIS, JERRY G. 56 ACT GS
106 WEST NORTHSIDE DR, VALDOSTA 31602
PUTNAM, JAMES R. 29 ACT OS,OPH
25 PRESCOTT ST NE #3401, ATLANTA 30308
PYBURN, ROBIN R. 34 ACT IM
660-H LANIER PARK DR, GAINESVILLE 30501

Q

QUANTZ, NEWTON G., JR. 54 ACT OTO
2283 WRIGHTSBORO RD, AUGUSTA 30904
QUARTERMAN, KEITH A., JR. 29 ACT GS
960 JOHNSON FERRY RD NE, ATLANTA 30342
QUATTLEBAUM, J.K., JR. 11 ACT GS
3710 WATERS AVE, SAVANNAH 31404
QUATTLEBAUM, J.K., SR. 11 ACT GS
3710 WATERS AVE, SAVANNAH 31404
QUATTLEBAUM, ROBERT B. 56 ACT R
2704-D NORTH OAK ST, VALDOSTA 31602
QUATTLEBAUM, ROBERT B., JR 11 ACT U
5354 REYNOLDS ST STE 416, SAVANNAH 31405
QUILALA, EMILIANO P. 16 ACT GS
252 ARROWHEAD BLVD, JONESBORO 30236
QUILLIAN, WILLARD E., III 54 ACT P
MEDICAL COLLEGE OF GEORGIA, AUGUSTA 30912
QUINN, CORINNE F. 13 ACT IM
LANGLEY DR, LAWRENCEVILLE 30245
QUINONES, PEORO P. 29 A PH
99 BUTLER ST SE, ATLANTA 30303

R

RAAEN, TOM O. 22 ACT PTH
2701 NORTH DECATUR RD, DECATUR 30033
RABB, FORTE C. 34 ACT D
327 NORTHSIDE DR NW, GAINESVILLE 30501
RABB, J.L. 31 ACT FP
MEDICAL ARTS CENTER, CALHOUN 30701
RABHAN, LEONARD J. 11 ACT GS
147 KEY HAVEN RD, KEY WEST FL 33040
RABUN, J.B. 11 ACT R
311 EAST HALL ST, SAVANNAH 31401
RAGHU, G.V. 36 ACT OBG
PO BOX 2105, WARNER ROBINS 31099
RAIFORD, MORGAN B. 29 ACT OPH
705 JUNIPER ST NE, ATLANTA 30308
RAILA, FRANK ARTHUR 42 S R
VA MEDICAL CENTER, AUGUSTA 30910
RAINER, JOEL H. 29 I&R CD
56 MOBILE AVE NE, ATLANTA 30305
RAINES, JACK A. 47 ACT P
3228 CODY RD, COLUMBUS 31907
RAITZ, ROBERT L. 76 ACT FP
1012 BURLEYSON DR, DALTON 30720
RAMAGE, JAMES E. 29 I&R IM
1101 COLLIER RD NW APT F2, ATLANTA 30318
RAMAIYA, NALINI K. 06 I&R FP
MEDICAL CENTER OF CENTRAL GA, MACON 31210
RAMOS, HAROLD S. 29 ACT IM
35 LINDEN AVE NE, ATLANTA 30308
RAMSEY, JOHN E. 29 ACT OBG
35 COLLIER RD STE 375, ATLANTA 30309
RAMSEY, SPEIR N. 11 ACT OBG
5354 REYNOLDS ST STE 318, SAVANNAH 31405
RAND, EDGAR O. 29 ACT GS
RTE 1, SAUTEE 30571
RANDALL, ALFRED H., JR. 17 ACT IM
641 CHURCH ST, MARIETTA 30060
RANDALL, R. BEAUVAIS, JR. 22 ACT IM
1275 MCCONNELL DR, DECATUR 30033
RANDO, STEPHEN 06 ACT R
770 PINE ST STE 250, MACON 31201
RANDOLPH, R.H. 15 ACT GS
740 PRINCE AVE, ATHENS 30601
RANDOLPH, W. QUENTIN 03 ACT FP
115 EAST WILLIAMS ST, WINDER 30680
RANGE, JOHN N. 34 ACT GP
RTE 2 BOX 8, OAKWOOD 30566
RANKIN, FRED M., JR. 06 ACT AN
MEDICAL CENTER OF CENTRAL GA, MACON 31204
RANKIN, JOSEPH L. 29 ACT D
384 PEACHTREE ST NE, ATLANTA 30308
RAO, MEENA 71 ACT US
1401 WEST SPRING ST, MONROE 30655
RAO, PULIPAKA B. 06 ACT IM,CD
770 PINE ST STE 460, MACON 31201

RAO, R.N. 54 ACT PTH
MEDICAL COLLEGE OF GEORGIA, AUGUSTA 30912
RAO, SANTEEV H.V. 42 ACT IM
VA MEDICAL CENTER, DUBLIN 31021
RAO, VARALAKSHMI N. 57 ACT OBG
PO BOX T, VIDALIA 30474
RAPER, HAL STUART 45 R US
THE FOUNDATION, WARM SPRINGS 31830
RASMUSSEN, E.P. 29 ACT R
35 COLLIER RD NW, ATLANTA 30309
RASMUSSEN, WARREN A. 30 ACT PH
PO BOX 1219, BRUNSWICK 31520
RATCHFORD, WALTER J. 29 ACT OBG
105 COLLIER RD NW #1080, ATLANTA 30309
RATHBUN, LAWRENCE A., JR. 11 ACT AN
515 EAST 63RD ST STE 3, SAVANNAH 31405
RATHUR, BABER ZAHEER 16 ACT EM
181 SW UPPER RIVERDALE RD, RIVERDALE 30274
RATTAN, KAMAL K. 13 ACT ORS
2121 FOUNTAIN DR STE E, SNELLVILLE 30278
RAUBER, ALBERT PAUL 22 ACT PD
BOX 459, ATLANTA 30322
RAUCH, SAMUEL OEAN 34 ACT IM
710 BROAD ST, GAINESVILLE 30501
RAUSHER, DAVIO B. 22 ACT IM,GE
1292 VISTA LEAF DR, DECATUR 30033
RAUTH, VIRGINIA A. 29 ACT TR
5665 PEACHTREE-DUNWOODY RD, ATLANTA 30342
RAVELO, FRANCISCO JOSE 56 ACT PTH
3914 FOXBOROUGH BLVD, VALDOSTA 31602
RAVELO, HUMBERTO C. 02 ACT P
CENTRAL STATE HOSPITAL, MILLEDGEVILLE 31061
RAVRY, MARIO J.R. 29 ACT GE
478 PEACHTREE ST NE, ATLANTA 30308
RAWLINGS, JOE D. 65 ACT FP
PO BOX 1617, THOMASVILLE 31792
RAWLINGS, WILLIAM 74 ACT FP
522 WASHINGTON AVE, SANDERSVILLE 31082
RAWLINGS, WILLIAM, JR. 74 ACT IM
522 WASHINGTON AVE, SANDERSVILLE 31082
RAWLS, OTIS GREY 23 ACT GS
910 NORTH JEFFERSON, ALBANY 31708
RAWLS, WILLIAM J. 22 ACT IM
755 COLUMBIA DR STE 912, DECATUR 30030
RAY, DERRELL W. 29 ACT P
2151 PEACHFORD RD, ATLANTA 30338
RAY, JAMES LEON 25 ACT FP
PO BOX 1330, SWAINSBORO 30401
RAY, JOHN W. 29 ACT R
1170 CLEVELAND AVE, EAST POINT 30344
RAY, LARRY G. 29 ACT
315 BOULEVARD NE STE 228, ATLANTA 30312
RAY, MICHAEL K. 17 ACT EM
677 CHURCH ST, MARIETTA 30060
RAY, WALKER L. 22 ACT PD
4112 E PONCE DE LEON AVE, CLARKSTON 30021
RAYBOURNE, JACK E. 06 ACT AN
2934 VICTORIA CIR, MACON 31201
RAYEL, PETER A. 29 ACT IM
6500 VERNON WOODS DR NE, ATLANTA 30328
RAYLE, ALBERT A., JR. 29 ACT R
490 PEACHTREE ST NE, ATLANTA 30308
RAYNOR, L. KENNETH, JR. 36 ACT OBG
PO BOX 2546, WARNER ROBINS 31093
RE, PETER K. 17 ACT N
522 NORTH AVE, MARIETTA 30060
READ, JOSEPH C. 29 ACT GS
1108 ELM ST, DANVILLE KY 40422
READ, SILAS C., JR. 15 ACT OPH
PO BOX 5518, ATHENS 30604
REAGAN, RONALD C. 22 I&R GS
300 BOULEVARD NE, ATLANTA 30312
REDD, BRYAN L., JR. 29 R TR
2662 FAIR OAKS RD, DECATUR 30033
REDD, STEPHEN S. 29 ACT PD
2758 FELTON DR, EAST POINT 30344
REDDY, ITHAMUKKALA J. 16 ACT GS
6507 PROFESSIONAL PL STE B, RIVERDALE 30274
REDDY, SUDHAKARA M. 08 ACT PD
PO BOX 488, STATESBORO 30458
REDDY, SUJATHA K. 42 ACT P
309 ST FRANCIS PL, DUBLIN 31021
REDFEARN, JAMES A., JR. 76 ACT IM
1209 MEMORIAL DR, DALTON 30720
REED, JOHN H., JR. 34 ACT OPH
1128 VINE ST NE, GAINESVILLE 30505
REED, RALPH EUGENE 60 ACT OPH
800 EAST DOYLE ST, TOCCOA 30577
REED, W. THOMAS 29 ACT IM
6500 VERNON WOODS DR, ATLANTA 30328
REES, BRIGITTA A. 29 ACT PM
3280 HOWELL MILL RD STE 309, ATLANTA 30327
REES, KLAUS O. 17 ACT CD
1001 THORNTON RD 107, LITHIA SPRINGS 30057
REESE, NORMAN O. 19 ACT AN
PO BOX 427, MOULTRIE 31768
REEVE, THOMAS E., JR. 10 ACT GS
619 DIXIE ST, CARROLLTON 30117
REEVES, J. LANE 11 ACT OPH
2 JACKSON BLVD, SAVANNAH 31405
REEVES, MARTIN M. 29 ACT AN
5360 TIMBER TR NE, ATLANTA 30342
REEVES, NATHAN 54 ACT IM
2264 WRIGHTSBORO RD, AUGUSTA 30904
REEVES, SEAB E.A. 42 R AN
PO BOX 1426, DUBLIN 31021
REEVES, W. HARRISON 29 ACT IM
478 PEACHTREE ST NE, ATLANTA 30308
REGALADO, JACINTO 02 ACT FP
PO BOX 600, HARDWICK 31034
REHERT, GERALD M. 29 ACT OBG
490 PEACHTREE ST STE 132-B, ATLANTA 30309
REICH, GEORGE A. 29 S PM
101 MARIETTA TOWER NW, ATLANTA 30323
REICH, ROBERT A. 22 ACT IM
755 COLUMBIA DR STE 905, DECATUR 30030
REICHERT, WILLIAM W. 22 ACT PUD
495 WINN WAY STE B-260, DECATUR 30030
REID, WILLIAM A. 29 ACT GS
340 BOULEVARD NE, ATLANTA 30312
REILLY, ENOS J. 17 R OBG
705 CAMPBELL HILL ST, MARIETTA 30060
REIMER, JONATHAN EDWARD 54 ACT FP
1224 WEST MARKS CHURCH RD, AUGUSTA 30909
REISH, MARTIN L. 17 ACT PD
2550 WINDY HILL RD STE 109, MARIETTA 30062
REISMAN, HOWARD A. 29 ACT OBG
11050 CRABAPPLE RD, ROSWELL 30075
REITT, J. PETER 29 ACT NS
993-F JOHNSON FERRY RD, ATLANTA 30342
REMIGAILO, RICHARD V. 22 ACT U
1462 MONTREAL RD #418, TUCKER 30084
REMINGTON, DAVE B. 59 ACT CD
116 WEST POPLAR ST, GRIFFIN 30223
RENN, WADE H. 56 ACT NS
200 EAST GORDON ST, VALDOSTA 31601
RENTZ, TURNER W. 30 ACT FP
2514 WREN ST, BRUNSWICK 31520
RENTZ, TURNER W., SR. 57 ACT
205 WEST MAIN, COLQUITT 31737
RETTERBUSH, DAVID W. 56 ACT GS
PO BOX 2313, VALDOSTA 31602
RETTERBUSH, W.C. 56 ACT GS
BOX 2313, VALDOSTA 31604
REVELL, WALTER J. 39 ACT FP
PO BOX 5, LOUISVILLE 30434
REY, CHARLES J., JR. 17 ACT GS
4399 AUSTELL RD, AUSTELL 30001
REYNAUD, L.F. 29 ACT PD
1278 GORDON ST SW, ATLANTA 30310
REYNAUD, VIRGINIA G. 29 ACT PD
1278 GORDON ST SW, ATLANTA 30310
REYNOLDS, G. THOMAS 65 ACT OBG
918 SOUTH BROAD ST, THOMASVILLE 31792
REYNOLDS, J.S. 29 ACT FP
553 MOBILE AVE SW, ATLANTA 30315
REYNOLDS, JAMES WILEY 26 ACT FP
PO BOX 549, ASHBURN 31714
REYNOLDS, JOHN O., III 54 ACT NS
820 ST SEBASTIAN WAY, AUGUSTA 30910
REYNOLDS, KENNETH H. 59 ACT IM
231 GRAEFE ST, GRIFFIN 30223
REYNOLDS, WILTON B., JR. 21 ACT FP
BOX 1075, BAINBRIDGE 31717
RHAME, DONALD W. 06 ACT GS
700 SPRING ST, MACON 31201
RHAME, MARLAN LEVAN 22 ACT P
497 WINN WAY #110-A, DECATUR 30030
RHANGOS, WILLIAM C. 11 ACT ORS
5354 REYNOLDS STE 505, SAVANNAH 31405
RHODE, C. MARTIN 54 R GS
2347 REDWOOD DR, AUGUSTA 30904
RHODES, E. LEON 27 ACT GS
HARBIN CLINIC, ROME 30161
RHODES, WILLIAM H., JR. 49 ACT FP
100 SCOTT ST, UNION POINT 30669
RICCAROI, LOUIS S. 29 R GS
1297 SWIMS VALLEY DR NW, ATLANTA 30327
RICE, M. HOBSON 22 ACT OPH
PO BOX 1798, DECATUR 30030
RICE, SAMUEL T. 47 ACT U
1021 TALBOTTON RD, COLUMBUS 31904
RICHARDS, CHARLES K. 27 ACT R
1104 MARTHA BERRY BLVD, ROME 30161
RICHARDSON, A. CULLEN, III 23 ACT GS
801 - 13TH AVE, ALBANY 31701
RICHAROSON, A. CULLEN, JR. 29 ACT OBG
105 COLLIER RD NW STE 3080, ATLANTA 30309
RICHARDSON, ARTHUR 29 ACT PA
977 CASTLE FALLS DR NE, ATLANTA 30322
RICHAROSON, CHARLES H., III 06 ACT ORS
770 PINE ST STE 400, MACON 31201
RICHAROSON, CHARLES R. 08 ACT OBG
PO BOX 1066, STATESBORO 30458
RICHARDSON, DEBORAH K. 54 ACT PTH
1402 WALTON WAY, AUGUSTA 30901
RICHAROSON, H. OALE 29 ACT NS
315 BOULEVARD NE STE 300, ATLANTA 30312
RICHARDSON, JAMES W. 60 ACT EM
STEPHENS COUNTY HOSPITAL, TOCCOA 30577
RICHAROSON, R.C. 23 ACT OTO
400 FOURTH AVE, ALBANY 31701
RICHAROSON, RUSSELL E. 34 ACT FP
700 SOUTH ENOTA DR NE, GAINESVILLE 30505
RICHARDSON, STERLING H. 29 ACT GS
490 PEACHTREE ST STE 356-B, ATLANTA 30308
RICHBOURG, HENRY R. 66 ACT FP
1223 EAST MCPHERSON, NASHVILLE 31639
RICHIN, PAUL F. 22 ACT ORS
497 WINN WAY, DECATUR 30030
RICHMAN, GARY O. 29 ACT OPH
993-D JOHNSON FERRY RD NE, ATLANTA 30342
RICHMOND, ALAN N. 29 ACT OBG
5667 PEACHTREE DUNWOODY RD, ATLANTA 30342
RICHMOND, JOHN D. 76 ACT IM,NEP
1406 BROADRICK DR, DALTON 30720
RICHMOND, LEA 29 ACT GS
6500 VERNON WOODS DR, ATLANTA 30328
RICKNER, THOMAS W. 42 ACT U
2406 BELLEVUE RD, DUBLIN 31021
RICKS, HENRY C., JR. 29 ACT P
1218 WEST PACES FERRY RD NW, ATLANTA 30327
RICKS, R. LEWIS 29 A OBG
1047 GORDON ST SW, ATLANTA 30310
RIDDELL, CHRISTOPHER F. 29 ACT P
1938 PEACHTREE RD NW, ATLANTA 30309
RIDLEY, C.L., JR. 06 ACT GS
TWO BACONSFIELD OFFICE PARK, MACON 31211

RIDLEY, JOHN H. 29 ACT GYN
35 COLLIER RD NW, ATLANTA 30309
RIEPE, STANLEY P. 29 ACT GE
69 BUTLER ST SE, ATLANTA 30303
RIESENBERG, ROBERT A. 22 ACT P
2754 N DECATUR RD STE 102, DECATUR 30030
RIESER, JOHN C. 29 ACT OPH
3280 HOWELL MILL RD STE 211, ATLANTA 30327
RIGAS, LAMBROS C. 27 ACT OBG
316 WEST TENTH ST, ROME 30161
RIGDON, STEVEN W. 66 ACT IM
712 EAST 18TH ST, TIFTON 31794
RIGEL, EDWARD PAUL 34 ACT AN
743 SPRING ST, GAINESVILLE 30505
RIGGINS, RICHARD S. 29 ACT ORS
1365 CLIFTON RD NE, ATLANTA 30322
RILEY, WELLS 16 ACT FP
151 WEST MILL, JONESBORO 30236
RIMANDO, LEONARDO F. 57 ACT GS
PO BOX 1185, VIDALIA 30474
RINKER, J. ROBERT 54 ACT U
MEDICAL COLLEGE OF GEORGIA, AUGUSTA 30902
RISSING, JOHN PETER 54 ACT IM
VA HOSPITAL DD, AUGUSTA 30910
RITCHEY, STERLING J. 29 ACT ORS

RITCHIE-HAYNES, PATRICIA 29 ACT OBG
1938 PEACHTREE RD NW STE 614, ATLANTA 30309
RITTER, LINDA B. 15 ACT AN
775 RIVERHILL DR, ATHENS 30606
RITTGERS, ROBIN A. 30 ACT IM,GE
3215 SHRINE RD, BRUNSWICK 31520
RIVENBURG, WILLEM K. 70 ACT IM
150 GROSS CRESCENT, FT OGLETHORPE 30742
RIVERS, JANE 47 A PD
2520 WYNNTON RD, COLUMBUS 31901
RIVERS, W.P., JR. 47 ACT PD
2520 WYNNTON RD, COLUMBUS 31906
RIVKIN, LAWRENCE M. 29 ACT TS
490 PEACHTREE ST NE, ATLANTA 30308
RIZOR, RANDY F. 29 ACT AN
11585 ALPHARETTA ST, ROSWELL 30076
ROACH, GEORGE S., JR. 29 ACT OTO
3280 HOWELL MILL RD STE 304, ATLANTA 30327
ROBBINS, RICHARD S. 47 ACT GE
1905 7TH AVE, COLUMBUS 31901
ROBERSON, PHIL E. 23 ACT GS
PO BOX 343, ALBANY 31702
ROBERTS, C. PURCELL 29 ACT IM
55-25TH ST NW, ATLANTA 30309
ROBERTS, DAVID B. 47 ACT OBG
2400 13TH ST, COLUMBUS 31906
ROBERTS, DON R., JR. 30 ACT ORS
3204 SHRINE RD, BRUNSWICK 31523
ROBERTS, DON W. 66 ACT IM
PO BOX 947, TIFTON 31793
ROBERTS, JOHN E. 17 ACT FP
1790 MULKEY RD STE 8-A, AUSTELL 30001
ROBERTS, LUTHER J. 47 ACT GS
2300 MANCHESTER RD UNIT F4, COLUMBUS 31904
ROBERTS, MICHAEL H. 23 ACT CDS
500 THIRD AVE, ALBANY 31701
ROBERTS, PHILLIP L. 23 ACT IM,HEM
500 THIRD AVE STE 109, ALBANY 31701
ROBERTS, RALPH D. 05 ACT FP
APOLLO DR, FITZGERALD 31750
ROBERTS, STEWART R., JR. 29 ACT R
1365 CLIFTON RD NE, ATLANTA 30322
ROBERTS, TERRELL S. 06 I&R FP
784 SPRING ST, MACON 31201
ROBERTSON, HARRY G. 29 ACT OPH
2200 NORTHLAKE PKY STE 325, TUCKER 30084
ROBERTSON, MASON G. 11 R IM
1221 LAWNDALE RD, SAVANNAH 31406
ROBERTSON, PAUL A. 17 ACT OS
PO BOX 7956, MARIETTA 30065
ROBERTSON, WILLIAM T. 17 ACT U
823 CAMPBELL HILL ST, MARIETTA 30060
ROBINSON, A. CLARK 32 ACT FP
PO BOX 1118, DOUGLASVILLE 30133
ROBINSON, DONALD R. 06 I&R OBG
PO BOX 1046, BOX ELDER SD 57719
ROBINSON, HENRY A., JR. 54 ACT OBG
3001 GORDON HWY HWY 78, GROVETOWN 30813
ROBINSON, J.C. 10 ACT R
605 DIXIE ST, CARROLLTON 30117
ROBINSON, JOE S. 06 ACT GS
770 PINE ST STE 320, MACON 31201
ROBINSON, JOE S. 06 ACT NS
740 HEMLOCK ST, MACON 31201
ROBINSON, JOHN H., III 61 ACT GS
629 EAST FORSYTH ST, AMERICUS 31709
ROBINSON, PAUL H. 29 ACT CD
1365 CLIFTON RD NE RM 481, ATLANTA 30322
ROBINSON, RALEIGH M. 15 ACT ORS
125 KING AVE, ATHENS 30610
ROBINSON, RALPH L. 29 R PD
156 MOUNT PARAN RD NW, ATLANTA 30327
ROBINSON, ROBERT S. 08 ACT GP
PO BOX 538, METTER 30439
ROBINSON, THEODORE RODNEY 34 ACT OM
PO BOX 2537, GAINESVILLE 30501
ROCHE, ROBERT R. 17 ACT R
3865 STORY DR SW, MARIETTA 30060
ROCHE, WILLIAM P., JR. 42 ACT IM
606 ACADEMY AVE, DUBLIN 31021
ROCKFELD, ROBERT D. 29 ACT ORS
4555 NORTH SHALLOWFORD RD, DUNWOODY 30338
RODDENBERRY, HARVEY B. 06 ACT OBG
380 HOSPITAL DR STE 100, MACON 31201
RODDENBERY, S.A. 47 ACT GS
213 DOCTORS BLDG, COLUMBUS 31901
RODRIGUEZ, A.P. 29 ACT U
340 BOULEVARD NE, ATLANTA 30312
RODRIGUEZ, ADRIANA M. 30 ACT R
3010 HAMPTON AVE, BRUNSWICK 31520
RODRIGUEZ, ANA G. 72 ACT AN
1908 ALICE ST, WAYCROSS 31501
RODRIGUEZ, ANTONIO R. 47 ACT IM
615-19TH ST, COLUMBUS 31901
RODRIGUEZ, FERNANDO 29 S IM
PO BOX 33115, N DECATUR 30033
RODRIGUEZ, MARTIN 29 ACT GP
4830 FULTON INDUSTRIAL BLVD, ATLANTA 30336
RODRIGUEZ-TORRES, JOSE O. 54 I&R PD
1660 MULKEY RD STE C, AUSTELL 30001
RODZEWICZ, PAUL J. 29 ACT IM
993-F JOHNSON FERRY RD NE, ATLANTA 30342
ROGERS, A.A., JR. 37 R FP
11 NORTH ELM ST, COMMERCE 30529
ROGERS, CHARLES G. 29 ACT OBG
993-D JOHNSON FERRY RD NE, ATLANTA 30042
ROGERS, D.MICHAEL 27 ACT GS
1825 MARTHA BERRY BLVD, ROME 30161
ROGERS, EDWARD A., JR. 19 ACT OBG
3011 FOURTH ST SE, MOULTRIE 31768
ROGERS, HARRISON L., JR. 29 ACT GS
1938 PEACHTREE RD NW #601, ATLANTA 30309
ROGERS, J. HARRY 29 ACT GS
418 ALLISON DR NE, ATLANTA 30342
ROGERS, J.V., JR. 22 ACT R
1365 CLIFTON RD, ATLANTA 30322
ROGERS, JAMES W. 06 R EM
3055 GENERAL LEE RD, MACON 31204
ROGERS, JIM LEE 27 ACT OBG
1105 NORTH FIFTH AVE, ROME 30161
ROGERS, JOHN J. 06 ACT GS
770 PINE ST STE 220, MACON 31201
ROGERS, PHILLIP R. 22 ACT FP
4553 NORTH SHALLOWFORD RD, ATLANTA 30338
ROGERS, T.E., JR. 06 ACT OBG
380 HOSPITAL DR, MACON 31201
ROJAS, ORLANDO O. 22 ACT
9 CORPORATE SQ NE STE 110, ATLANTA 30329
ROLLINGS, HARRY E. 11 ACT IM
100 EAST PARK AVE, SAVANNAH 31401
ROLLINS, LUTHER C. 29 ACT GS
35 COLLIER RD NW, ATLANTA 30309
ROMAN, CARLOS R. 29 ACT AN
2760-B FELTON DR, EAST POINT 30344
ROMINE, BENJAMIN W. 65 ACT FP
PO BOX 232, QUITMAN 31643
ROOF, JACK B., JR. 07 ACT FP
PO BOX 1108, BLUE RIDGE 30513
ROOKER, DONALD W. 29 ACT OTO
833 CAMPBELL HILL RD, MARIETTA 30060
ROPER, E.A. 14 ACT FP
708 CHURCH ST, JASPER 30143
ROPER, RONALD P. 17 ACT U
823 CAMPBELL HILL ST, MARIETTA 30060
ROSE, CORDT E. 69 R AN
6 KEELSON LN, SAVANNAH 31411
ROSE, DANIEL W. 11 ACT OTO,AL
17 MEDICAL ARTS CENTER, SAVANNAH 31405
ROSE, FRED D. 48 ACT IM
340 BOULEVARD NE STE 245, ATLANTA 30312
ROSEN, ARNOLD J. 29 ACT GS
993-D JOHNSON FERRY RD NE, ATLANTA 30342
ROSEN, RONALD 17 ACT U
1620 MULKEY RD, AUSTELL 30001
ROSEN, RONALD M. 22 ACT CHP
1935 CLIFF VALLEY WAY NE, ATLANTA 30329
ROSEN, SAMUEL F. 11 ACT D
PO BOX 960, SAVANNAH BEACH 31328
ROSENBAUM, BARRY J. 22 ACT NEP
497 WINN WAY NE STE A-210, DECATUR 30030
ROSENBLOOM, SEYMOUR J. 17 ACT IM
833 CAMPBELL HILL ST, MARIETTA 30090
ROSENFELD, JOSEPH M. 22 ACT PD
5008 SNAPFINGER WOODS DR, DECATUR 30035
ROSENGART, CARL L. 11 ACT N
23 WEST GORDON ST, SAVANNAH 31401
ROSENTHAL, DAVID 29 ACT OS
315 BOULEVARD NE, ATLANTA 30312
ROSHTO, JAMES A. 08 ACT OBG
PO BOX 1066, STATESBORO 30458
ROSS, JACK R. 47 I&R FP
THE MEDICAL CENTER, COLUMBUS 31994
ROSS, JOHN W. 17 ACT PTH
677 CHURCH ST, MARIETTA 30060
ROSS, MILLARD I. 48 ACT GS
1359 MILSTEAD RD #202, CONYERS 30207
ROSSI, TONI L. 29 ACT IM
484 MORELAND AVE STE 300, ATLANTA 30307
ROSSITER, FRANCIS P., JR. 11 ACT PDA,AL
5 MIDTOWN MEDICAL CENTER, SAVANNAH 31401
ROSSNER, STEPHEN D. 17 ACT CD
670 CHEROKEE ST, MARIETTA 30060
ROSSOMONDO, ROGER M. 10 ACT OPH
101 CLINIC AVE, CARROLLTON 30117
ROSVOLL, RANDI V. 29 ACT PTH,BLB
35 LINDEN AVE NE, ATLANTA 30308
ROTHENBERG, MARVIN B. 29 ACT ORS
6500 VERNON WOODS DR NE, ATLANTA 30328
ROTTENBERG, HOWARD A. 29 ACT U
5667 PEACHTREE DUNWOODY RD, ATLANTA 30342
ROTTERSMAN, WILLIAM 29 ACT P
STE 300, ATLANTA 30327
ROUBEN, DAVID P. 29 ACT ORS
315 BOULEVARD NE, ATLANTA 30312
ROUGHTON, RALPH E., JR. 29 ACT P
1175 PEACHTREE ST NE, ATLANTA 30309
ROULE, J. VICTOR 54 ACT OTO
2251 CUMMING RD, AUGUSTA 30904
ROUNTREE, CLYDE B. 22 ACT P
755 COLUMBIA DR STE 418, DECATUR 30030
ROUTLEDGE, JAMES A. 27 ACT GS
310 WEST SIXTH ST, ROME 30161

ROUTON, JAMES L. 11 ACT AN
5354 REYNOLDS ST STE 518, SAVANNAH 31405
ROWE, THOMAS S. 29 ACT OPH
490 PEACHTREE ST NE, ATLANTA 30308
ROWELL, ROGER R. 22 ACT OPH
PO BOX 1798, DECATUR 30030
ROWLAND, DAVID M. 22 ACT U
755 COLUMBIA DR STE 520, DECATUR 30030
ROWLAND, J. ROY, JR. 42 ACT FP
MEDICAL CENTER, DUBLIN 31021
ROWLAND, JAMES M., III 06 ACT IM
770 PINE ST STE 410, MACON 31201
ROWLEY, CHARLES M. 06 ACT N
740 HEMLOCK ST, MACON 31201
ROZIER, D.H. 06 ACT AN
5151 ZEBULON RD, MACON 31204
RUBENSTEIN, ARNOLD B. 16 ACT U
29 SW UPPER RIVERDALE RD, RIVERDALE 30274
RUBIN, JOSEPH W. 54 ACT TS
MEDICAL COLLEGE OF GEORGIA, AUGUSTA 30912
RUBIN, ROY MICHAEL 29 ACT ORS
5669 PEACHTREE-DUNWOODY RD, ATLANTA 30342
RUCKER, J.T., JR. 54 ACT AN
812 13TH ST, AUGUSTA 30901
RUCKET, ALAN N. 29 ACT OBG
315 BOULEVARD NE, ATLANTA 30312
RUDDER, FRED F. 29 ACT GS
350 BOULEVARD NE, ATLANTA 30312
RUDE, JOE CHRISTOPHER 17 ACT R
3865 STOREY DR SW, MARIETTA 30060
RUDER, ERNST M. 29 ACT R
1175 WEST GARMON RD, ATLANTA 30327
RUDOLPH, STEPHEN J., JR. 18 R OM
702 NORTH GASKIN AVE, DOUGLAS 31533
RUDY, RICHARD K. 29 S FP,PM
205 THIRD ST NE STE 4, ATLANTA 30308
RUF, LAWRENCE E. 11 ACT PS,MFS
515 EAST 63RD ST, SAVANNAH 31405
RUMBLE, CHARLES T. 06 ACT PD
RUMBLE RD E RTE 3 BOX 43, FORSYTH 31029
RUNDLE, T.J. 61 ACT OPH
PO BOX 1026, AMERICUS 31709
RUPAREL, HARESH M. 65 ACT IM
PO BOX 845, QUITMAN 31643
RUPPEL, JAMES W. 14 ACT FP
110 WALESKA RD, CANTON 30114
RUSCA, JOHN A. 29 ACT PS
5667 PEACHTREE DUNWOODY RD, ATLANTA 30342
RUSHTON, HARRY G., JR. 17 ACT U
660 CHEROKEE ST, MARIETTA 30060
RUSSELL, ALEX P. 11 ACT PTH
PO BOX 23103, SAVANNAH 31403
RUSSELL, E.K. 29 ACT IM
600 WEST PEACHTREE ST NE, ATLANTA 30308
RUSSELL, R. JAMES 29 ACT PS
3250 HOWELL MILL RD NW, ATLANTA 30327
RUTLEDGE, JOHN H. 72 ACT OBG
2005-D PIONEER ST, WAYCROSS 31501
RYCHLY, ROBERT E. 54 ACT IM
820 ST SEBASTIAN WAY STE 7-A, AUGUSTA 30901

S

SABA, JOSEPH N. 16 ACT N
1135 HUDSON BRIDGE RD, STOCKBRIDGE 30281
SABET, REZA M. 68 ACT N
1550 DOCTORS DR, LA GRANGE 30240
SABRIN, RUSSELL L. 29 ACT ORS
11050 CRABAPPLE RD, ROSWELL 30075
SACKS, HARVEY N. 29 ACT CD
315 BOULEVARD NE STE 520, ATLANTA 30312
SACKS, LEONARD L. 29 ACT NPM
1968 PEACHTREE RD, ATLANTA 30309
SAFER, IRWIN H. 11 ACT P
515 EAST 63RD ST, SAVANNAH 31405
SAFER, LESLIE F. 23 ACT D
426 SECOND AVE, ALBANY 31701
SAFFAN, B.D. 29 ACT IM
25 PRESCOTT ST NE STE 6410, ATLANTA 30308
SAFLEY, BRENDA R. 23 ACT AN
2605 WEST DOUBLE GATE DR, ALBANY 31707
SAFLEY, WILLIAM L. 23 ACT TS
500 THIRD AVE, ALBANY 31701
SAFRA, MARK J. 22 ACT OPH
1276 MCCONNELL DR, DECATUR 30033
SAKER, A.F. 29 ACT OBG
1311 EAST CLEVELAND AVE, EAST POINT 30341
SALANGA, ROGELIO B. 56 ACT GS
PO BOX 908, NASHVILLE 31639
SALE, WALTER T. 29 ACT R
35 COLLIER RD NW, ATLANTA 30309
SALEEBY, PHILIP R. 30 ACT IM,PUD
3212 SHRINE RD, BRUNSWICK 31520
SALEHBHAI, MANSOOR 36 ACT PD
1049 NORTH HOUSTON RD, WARNER ROBINS 31093
SAMMONS, EDWARD E. 29 ACT AN
EMORY UNIVERSITY HOSPITAL, ATLANTA 30322
SAMPAT, JAYSHREE H. 23 ACT DR
PO BOX 1924, ALBANY 31703
SAMPSON, BRUCE D. 36 ACT IM
1019 KEITH DR, PERRY 31069
SAMPSON, LLOYD B. 47 ACT D
1408 THIRD AVE, COLUMBUS 31901
SAMS, FERROL A., III 16 ACT IM
675 NORTH JEFF DAVIS DR, FAYETTEVILLE 30214
SAMS, FERROL A., JR. 16 ACT FP
675 NORTH JEFF DAVIS, FAYETTEVILLE 30214
SAMS, FRANK H., JR. 36 ACT FP
BOX 536, REYNOLDS 31076
SAMS, HELEN F. 16 ACT GP
675 JEFF DAVIS, FAYETTEVILLE 30214
SAMS, JAMES C. 16 ACT IM
675 NORTH JEFF DAVIS DR, FAYETTEVILLE 30214
SAMS, WILLIAM C., JR. 05 ACT FP
107 EAST THIRD ST, OCILLA 31774
SANCHEZ, ELIO S. 27 ACT IM
6 COACH TR SE, ROME 30161
SANCHEZ, GEORGE L. 47 I&R
837 EDEN ST, COLUMBUS 31904
SANDBERG, JOHN 17 ACT PD
969 CHEROKEE RD STE L, SMYRNA 30080
SANDERS, BEVERLY B., JR. 06 ACT D
1157 FORSYTH ST, MACON 31201
SANDERS, C. VERNON 29 ACT IM
6500 VERNON WOODS DR NE, ATLANTA 30328
SANDERS, CONRAD W., JR. 54 ACT GS
1430 HARPER ST, AUGUSTA 30902
SANDERS, DRAYTON M. 76 ACT
1217 MEMORIAL DR, DALTON 30720
SANDERS, F. HUNT 36 ACT AN
PO BOX 2605, WARNER ROBINS 31093
SANDERS, FLOYD R., JR. 22 ACT FP
603 CHURCH ST, DECATUR 30030
SANDERS, GERALD E. 17 ACT OPH
653 CHEROKEE ST, MARIETTA 30060
SANDERS, HARVEY J., JR. 09 ACT IM
304 JONES AVE, WAYNESBORO 30830
SANDERS, HERBERT F. 11 ACT N
4 JACKSON BLVD, SAVANNAH 31405
SANDERS, J. LARRY 76 ACT OBG
1108 PROFESSIONAL BLVD, DALTON 30720
SANDERS, JOHN W. 23 ACT PD
412 FOURTH AVE, ALBANY 31701
SANDERS, RICHARD A. 47 ACT ORS
6262 HAMILTON RD, COLUMBUS 31904
SANDERS, RUTH T. 54 ACT R
PO BOX 3658, AUGUSTA 30904
SANDERS, STEVEN L. 29 ACT GS
5667 PEACHTREE DUNWOODY RD, ATLANTA 30342
SANDVI, M. ASLAM 76 ACT P
PO BOX 1648, DALTON 30720
SANS, DIEGO C. 02 ACT P
CENTRAL STATE HOSPITAL, MILLEDGEVILLE 31062
SANTIAGO, ARMANDO 57 ACT GP
401 WEST BROAD ST, LYONS 30436
SANTIAGO, MARCELO R. 08 ACT GS
PO BOX 800, CLAXTON 30417
SANTOS, TEODORO DE LOS 56 ACT PTH
PO BOX 1727, VALDOSTA 31601
SAPP, GERALD L. 66 ACT ORS
PO BOX 1368, TIFTON 31793
SAPP, PHILIP B. 76 ACT EM
PO BOX 98, ROCKY FACE 30740
SARANGI, SARUDIN J.N. 16 ACT RHU
238 PROFESSIONAL CT, RIVERDALE 30274
SARGENT, CARLTON W. 29 ACT OBG
6553 CHURCH ST, RIVERDALE 30274
SARMA, PUDIPEDDI R. 29 S HEM,ON
1670 CLAIRMONT RD, DECATUR 30033
SATCHER, MILTON B., JR. 29 ACT ORS
2788 BAYARD ST, EAST POINT 30344
SATHE, ANAND J. 42 ACT OBG
107 VERNON ST, DUBLIN 31021
SAUNDERS, ELWYN A. 54 ACT ORS
MEDICAL COLLEGE OF GEORGIA, AUGUSTA 30912
SAVAGE, C.P. 61 ACT FP
524 SUMTER ST, MONTEZUMA 31063
SAVAGE, JOHN B. 54 ACT ORS
3623 J DEWEY GRAY CIR, MARTINEZ 30909
SAWYER, JAMES L. 72 R P
1515 CHEROKEE DR, WAYCROSS 31501
SAX, CHARLES E. 11 ACT OBG
1216 SWEETBRIAR CIR, SAVANNAH 31406
SAXENA, VIRENDRA M. 58 ACT GS
PO BOX 54, FT GAINES 31751
SAYE, WILLIAM B. 17 ACT OBG
792 CHURCH ST STE 4, MARIETTA 30060
SCALJON, WILLIAM M. 29 ACT U
35 COLLIER RD NW #700, ATLANTA 30309
SCANLON, BARRY F. 29 ACT P
1201 PEACHTREE ST NE, ATLANTA 30361
SCARBOROUGH, DAVID W. 08 ACT FP
412 NORTHSIDE DR, STATESBORO 30458
SCARBROUGH, ROGER W., JR. 11 ACT OBG
5354 REYNOLDS ST STE 424, SAVANNAH 31405
SCARDINO, PETER L. 11 ACT U
2515 HABERSHAM ST, SAVANNAH 31499
SCHAFFNER, DONALD P. 29 ACT GP,PDS
993-D JOHNSON FERRY RD NE, ATLANTA 30342
SCHATTEN, WILLIAM E. 29 ACT PS
3280 HOWELL MILL RD NW, ATLANTA 30327
SCHEIDT, KENNETH A. 29 ACT NM
25 PRESCOTT ST NE, ATLANTA 30308
SCHEINBAUM, C.N. 29 ACT
928 NORTH HIGHLAND AVE NE, ATLANTA 30306
SCHELLACK, J.K. 29 ACT GS
490 PEACHTREE ST NE, ATLANTA 30308
SCHERMERHORN, THOMAS J. 29 ACT OPH
384 PEACHTREE ST NE, ATLANTA 30308
SCHERR, JOHN M. 29 ACT IM
105 COLLIER RD STE 4030, ATLANTA 30309
SCHILLING, ROBINSON W., JR. 54 ACT OTO
2283 WRIGHTSBORO RD, AUGUSTA 30904
SCHLACHTER, LAWRENCE B. 17 ACT NS
1057 FIELDING WAY, MARIETTA 30067
SCHLANT, ROBERT C. 29 ACT IM
69 BUTLER ST SE, ATLANTA 30303
SCHLEY, FRANCIS B., JR. 47 ACT PD
303 11TH ST, COLUMBUS 31901
SCHLEY, MARY W. 47 ACT PD
1527 FOREST AVE, COLUMBUS 31906
SCHLEY, PHILIP T. 47 ACT U
2001 HAMILTON RD, COLUMBUS 31904
SCHLEY, RICHARD L., JR. 11 ACT PD
5509 PAULSEN ST, SAVANNAH 31405
SCHLOSSBERG, MICHAEL 29 ACT OBG
2788 BAYARD ST, EAST POINT 30344

SCHLOTTMAN, GEORGE C. 06 ACT U
718 FIRST ST, MACON 31201
SCHMIDT, DAVID M. 17 ACT U
823 CAMPBELL HILL ST, MARIETTA 30060
SCHMIDT, DON 27 S FP
NAVAL HOSPITAL, MILLINGTON TN 38054
SCHMIOT, F.K. 17 ACT U
823 CAMPBELL HILL ST, MARIETTA 30060
SCHMITT, ELBERT W., JR. 29 ACT ORS
1365 CLIFTON RD NE, ATLANTA 30322
SCHNAPPER, ROBERT A. 29 ACT N
315 BOULEVARD NE STE 224, ATLANTA 30312
SCHNEIDER, M.M. 11 ACT OBG
19 MEDICAL ARTS CENTER, SAVANNAH 31405
SCHNEIDERMAN, STEVEN M. 22 ACT IM
2712 NORTH DECATUR RD, DECATUR 30033
SCHNELL, FREDERICK M. 06 ACT HEM,ON
729 PINE ST, MACON 31201
SCHNUCK, LLOYO B., JR. 11 ACT R
9 MEDICAL ARTS CENTER, SAVANNAH 31405
SCHOBORG, THOMAS W. 29 ACT U
340 BOULEVARD NE STE 11, ATLANTA 30312
SCHREEOER, JOHN M. 22 R FP
4165 CHAMBLEE-DUNWOODY RD, CHAMBLEE 30341
SCHRODER, J. SPALDING 29 ACT IM
1365 CLIFTON RD NE, ATLANTA 30322
SCHUESSLER, CARL C. 06 ACT OBG
380 HOSPITAL DR, MACON 31201
SCHUESSLER, GEORGE 47 ACT FP
2854 LYNDA LN, COLUMBUS 31906
SCHULTZ, ROBERT M. 29 ACT PDE,DIA
993-C JOHNSON FERRY RD NE, ATLANTA 30342
SCHULZE, RICHARD R. 11 ACT OPH
728 EAST 67TH ST, SAVANNAH 31405
SCHUMAN, BERNARD M. 54 ACT IM,GE
MEDICAL COLLEGE OF GEORGIA, AUGUSTA 30912
SCHWARTZ, FRED J. 29 ACT AN
35 COLLIER RD NW STE 560, ATLANTA 30309
SCHWARTZ, JAMES F. 29 ACT CHN
69 BUTLER ST SE, ATLANTA 30303
SCHWARTZ, LARRY A. 06 ACT PD
376 ROGERS AVE, MACON 31204
SCHWARTZ, ROBERT I. 06 ACT PD
376 ROGERS AVE, MACON 31204
SCHWARTZ, RONALO O. 23 ACT OBG
ALBANY TOWERS STE 316, ALBANY 31701
SCHWARTZ, SANFORD H. 29 ACT IM
4536 CHAMBLEE-DUNWOODY RD, ATLANTA 30338
SCHWARZMANN, STEPHEN W. 29 ACT ID
1365 CLIFTON RD NE, ATLANTA 30322
SCHWIN, ROBERT L. 29 ACT P
281 BOULEVARD NE, ATLANTA 30312
SCIPLE, GEORGE W. 30 ACT P
2601 PARKWOOD DR, BRUNSWICK 31520
SCOGGINS, BERNARD P. 23 ACT IM
1700 EAST BROAD AVE, ALBANY 31705
SCOGGINS, BRENOA B. 54 ACT P
136 LAKEWOOD PL BOX 55, GRACEWOOD 30812
SCOGGINS, HENRY O. 54 ACT OBG
1500 JOHNS RD, AUGUSTA 30904
SCOTT, CHARLES, JR. 29 ACT U
340 BOULEVARD NE, ATLANTA 30312
SCOTT, JAMES I. 11 ACT GS
9-A MEDICAL ARTS CENTER, SAVANNAH 31405
SCOTT, JAMES W. 66 ACT ORS
PO BOX 1827, TIFTON 31793
SCOTT, THOMAS P., JR. 29 ACT PD
777 CLEVELAND AVE SW, ATLANTA 30315
SCOTT, WILBUR M. 02 ACT GS
PO BOX 867, MILLEDGEVILLE 31061
SCOTT, WILLIAM M.W. 29 ACT P
2151 PEACHFORD RD, ATLANTA 30338
SEAGO, RICHARD W. 10 ACT GS
405 ALABAMA AVE, BREMEN 30110
SEALEY, R. MITCHELL 29 ACT OBG
993-D JOHNSON FERRY RD NE, ATLANTA 30042
SEALY, HUGH K. 06 ACT IM
765 SPRING ST, MACON 31201
SEARCY, ASHBURN P. 17 ACT AN
6430 RIVER CHASE CIR NW, ATLANTA 30328
SEARS, ROBERT A. 06 R NS
510 HIGH POINT N, MACON 31210
SEAVEY, PAUL W. 29 ACT IM
1365 CLIFTON RD NE, ATLANTA 30322
SEBAS, JOHN A. 43 ACT FP
PO BOX 262, DAWSONVILLE 30534
SEESE, PERRY G. 22 ACT P
1970 CLIFF VALLEY WAY ' 218, ATLANTA 30329
SEGALL, NATHAN 29 ACT A,IM
478 PEACHTREE ST NE, ATLANTA 30308
SEGARS, JAMES H., JR. 70 ACT GP
PRIMARY HEALTH CENTER, TRENTON 30752
SEGERBERG, ERIC C. 30 ACT GS
3215 SHRINE RD, BRUNSWICK 31520
SEHGAL, NARINOER N. 54 ACT OBG
1350 WALTON WAY, AUGUSTA 30901
SELF, STANLEY J. 27 ACT D
302 WEST SIXTH ST, ROME 30161
SELF, THOMAS A. 31 ACT FP
#4 HOSPITAL CT, CALHOUN 30701
SELL, M.B., JR. 54 ACT P
MEDICAL COLLEGE OF GEORGIA, AUGUSTA 30912
SELLERS, SIDNEY L. 76 ACT GYN
PO BOX 989, DALTON 30720
SELMONOSKY, CARLOS A. 17 ACT TS
1660 MULKEY RD STE A, AUSTELL 30001
SENEVIRATNE, D.G. 47 ACT EM
7158 STANDING BOY RD, COLUMBUS 31904
SENNETT, CHARLIE O., JR. 27 ACT PTH
FLOYD HOSPITAL, ROME 30161
SERGENT, PAUL M. 37 ACT FP
335 SOUTH BROAD ST, COMMERCE 30529
SERRA, MARIAN H. 29 I&R EM
80 BUTLER ST, ATLANTA 30303
SERRATO, J.C., JR. 47 ACT ORS
DOCTORS BLDG #320, COLUMBUS 31901
SERVY, EOOUARD JEAN 54 ACT OBG
812 CHAFEE AVE, AUGUSTA 30904
SESSIONS, GEORGE P. 22 ACT AN
755 COLUMBIA DR STE 413, DECATUR 30030
SESSIONS, ROBERT T. 17 ACT GS
811 CHURCH ST, MARIETTA 30060
SETTLE, JAMES, JR. 29 ACT PUD
3250 HOWELL MILL RD STE 301, ATLANTA 30327
SETZER, EDWARD H. 60 ACT IM
800 EAST DOYLE ST, TOCCOA 30577
SEVERS, RONALD G. 36 ACT GS
105-B BRIARCLIFF, WARNER ROBINS 31093
SEYMOUR, GLENN E. 23 ACT GS
410 FOURTH AVE, ALBANY 31701
SHACKELFORD, HUGH W. 29 ACT DR
993 JOHNSON FERRY RD NE, ATLANTA 30342
SHACKLETT, ROBERT S. 69 ACT PTH
PO BOX 1059, THOMASTON 30286
SHADEED, BAHEEG L. 29 ACT GS
1776 OLD SPRING HOUSE LN, DUNWOODY 30338
SHAFFER, CARY 30 ACT FP,EM
203 FIVE POUNDS RD, ST SIMONS IS 31522
SHAH, INDRA C. 66 ACT IM
1801 OLD OCILLA RD, TIFTON 31794
SHAH, KAMLA J. 54 ACT TR
MEDICAL COLLEGE OF GEORGIA, AUGUSTA 30912
SHAH, KAUSHIK S. 15 ACT OBG
1077 BAXTER ST, ATHENS 30606
SHAH, KIRITKUMAR J. 32 ACT GP,P
9507 HIGHWAY 5, DOUGLASVILLE 30135
SHAH, NARENDRA K. 15 ACT R
1199 PRINCE AVE, ATHENS 30613
SHAKER, ISSAM JOHN 06 ACT CDS
770 PINE ST STE 300, MACON 31201
SHAMA, ZOUTHEIR A. 29 ACT GS
2536 COSMOS DR NE, ATLANTA 30329
SHANIK, EDWARD J. 29 ACT FP
1585 HOLCOMB BRIDGE RD, ROSWELL 30076
SHANKS, JAMES Z. 29 ACT IM
1005 HAMMOND DR, ATLANTA 30328
SHANNON, GEORGE W. 47 ACT FP,IM
PO BOX 951, COLUMBUS 31994
SHANTHA, TOTADA R. 29 ACT AN
300 BOULEVARD NE STE 243, ATLANTA 30312
SHAPIRO, STANLEY T. 17 ACT OTO
2550 WINDY HILL RD #106, MARIETTA 30067
SHARON, ZEEV 22 ACT IM,NEP
497 WINN WAY STE A-210, DECATUR 30030
SHARPTON, JULIAN D. 28 ACT FP
PO BOX 938, HARTWELL 30643
SHAW, GEORGE P., JR. 70 ACT FP
105 EAST PATTON, LAFAYETTE 30728
SHAW, MATTHEW C. 17 ACT AN
PO BOX 1547, MARIETTA 30061
SHEA, P.C., JR. 29 ACT GS
1510 BENT CREEK CT, DUNWOODY 30338
SHEALY, L.M. 65 ACT FP
PO BOX 631, QUITMAN 31643
SHEAR, GLENN S. 16 ACT OPH
33 UPPER RIVERDALE RD, RIVERDALE 30274
SHEFFIELD, PHILIP 15 ACT OTO
1010 PRINCE AVE, ATHENS 30601
SHEHEE, WALTER H. 29 ACT P
1338 CLEVELAND AVE, EAST POINT 30344
SHEILS, ANDREW T., JR. 11 ACT ORS
7 ST JOSEPHS PROF PLAZA, SAVANNAH 31406
SHEILS, WAYNE C. 47 ACT R
DRAWER 2787, COLUMBUS 31902
SHELTON, LEE RAYMOND 29 A GS
2797 CAMPBELLTON RD, ATLANTA 30311
SHEPARD, JACK N. 72 ACT OBG
PO BOX 280, ALMA 31510
SHEPARD, KIRK 65 ACT GS
204 JUNIUS ST, THOMASVILLE 31792
SHEPHERD, EDWIN C. 11 ACT PD
4 MEDICAL ARTS CENTER, SAVANNAH 31405
SHEPHERD, MASON H. 54 ACT GS
1430 HARPER ST, AUGUSTA 30902
SHERLINE, DONALD 54 ACT OBG
MEDICAL COLLEGE OF GEORGIA, AUGUSTA 30912
SHERMAN, ELOISE B. 11 ACT PTH
1710 EAST HENRY ST, SAVANNAH 31404
SHERMAN, HARRY C. 54 ACT GS
1430 HARPER ST, AUGUSTA 30902
SHERMAN, HENRY T. 56 ACT IM
604 GEORGIA AVE, VALDOSTA 31601
SHERMAN, JERALD J. 29 ACT OBG
2550 WINDY HILL RD #108, MARIETTA 30067
SHERMAN, ROGER T. 29 ACT GS
69 BUTLER ST SE, ATLANTA 30303
SHERMAN, STANLEY WILLIAM 22 ACT IM
495 WINN WAY STE B-260, DECATUR 30030
SHERRER, CARL WILLIS 29 ACT OBG
105 COLLIER RD NW STE 1080, ATLANTA 30309
SHERRER, DOROTHY 17 ACT P
3188 ATLANTA ST SE, SMYRNA 30080
SHERRER, WEBSTER A. 17 ACT PTH
833 CAMPBELL HILL ST ' 111, MARIETTA 30090
SHERRILL, REGINALD R. 76 ACT PS
1111 PROFESSIONAL BLVD, DALTON 30720
SHESSEL, FRED S. 29 ACT U
5669 PEACHTREEE DUNWOODY RD, ATLANTA 30342
SHESSEL, HERBERT L. 29 ACT OBG
315 BOULEVARD NE STE 328, ATLANTA 30312
SHETTY, NARAYAN SESU 37 ACT PD
92 HOSPITAL RD, COMMERCE 30529
SHETTY, YESHWANTHI 22 ACT P
2531 BRIARCLIFF RD #211, ATLANTA 30329
SHIELDS, JOSEPH O., III 06 ACT IM
618 ORANGE ST, MACON 31201
SHIFLET, ROBERT E. 15 R U
165 CEDAR CREEK DR, ATHENS 30605

SHIH, CHEN-WEN 62 ACT OBG
212 FRASER DR, HINESVILLE 31313
SHIN, YOUNG SHIK 16 ACT PD,A
1135 HUDSON BRIDGE RD, STOCKBRIDGE 30281
SHIRAZI, SYED H. 29 ACT IM,CD
4555 NORTH SHALLOWFORD RD, DUNWOODY 30338
SHIRLEY, RUOY M. 76 ACT OTO
1436 BROADRICK DR, DALTON 30720
SHIRLEY, WILLIAM C. 06 ACT OBG
380 HOSPITAL DR #100, MACON 31201
SHIVER, CHARLES B. 54 ACT IM
806-13TH ST, AUGUSTA 30901
SHIVER, R.B., JR. 46 ACT FP
25 PERRY ST, CAMILLA 31730
SHIVERS, OLIN G. 29 ACT PD
47 PEACHTREE PARK DR NE, ATLANTA 30309
SHLAER, STEPHEN M. 54 ACT ON
820 ST SEBASTIAN WAY, AUGUSTA 30910
SHULER, ROBERT K. 29 ACT PD
105 COLLIER RD NW STE 4060, ATLANTA 30309
SHULMAN, MICHAEL G. 29 ACT IM,NEP
5669 PEACHTREE-DUNWOODY RD, ATLANTA 30342
SHUMAN, IVY L., JR. 55 ACT FP
211 MIMS RD, SYLVANIA 30467
SHUMAN, MONTY B. 42 ACT FP
MEDICAL CENTER, DUBLIN 31021
SHUMAN, ROBERT O. 42 ACT IM
606 ACADEMY AVE, DUBLIN 31021
SHUMAN, VILOA 72 ACT PD
520 BUNN BLDG, WAYCROSS 31501
SIEGEL, DONALO 22 ACT GS
755 COLUMBIA DR STE 717, DECATUR 30030
SIEVERT, ALAN J. 29 ACT ADL,PD
3108 DODSON DR, EAST POINT 30344
SIGAL, HOWARO MARVIN 17 ACT PD
3001 SOUTH COBB DR SE, SMYRNA 30080
SIGMAN, CHENEY C. 15 ACT PD
116 WOODLANDS RD, WATKINSVILLE 30677
SIGMAN, HOLLIS D. 47 ACT AN
404 DOCTORS BLDG, COLUMBUS 31901
SIKES, JAMES C. 06 ACT P
803 SPRING ST, MACON 31201
SIKES, ZACHARIAH S., JR. 06 R P
259 IDLE WILD RD, MACON 31210
SILAN, J. RUBEN O. 62 ACT GS
PO BOX 844, HINESVILLE 31313
SILFEN, SHERYL L. 22 ACT OBG
465 WINN WAY STE 100, DECATUR 30030
SILLER, EVERARD J. 06 ACT N
829 FIRST ST, MACON 31201
SILVER, JEROME I. 34 ACT R
11585 ALPHARETTA ST, ROSWELL 30076
SILVER, WILLIAM E. 29 ACT OTO,PS
4553 NORTH SHALLOWFORD RD, ATLANTA 30338
SILVERMAN, BARRY O. 29 ACT CD
1000 JOHNSON FERRY RD NE, ATLANTA 30342
SILVERMAN, MARK E. 29 ACT IM
1968 PEACHTREE RD NW, ATLANTA 30309
SILVERMAN, STUART H. 22 ACT OPH
5040 SNAPFINGER WOODS DR, DECATUR 30035
SILVERMAN, VICTOR E. 29 ACT IM
4536 CHAMBLEE-DUNWOODY RD, ATLANTA 30338
SILVERSTEIN, CHARLES M. 29 ACT R
1000 JOHNSON FERRY RD NE, ATLANTA 30342
SIMMONS, BERNARD RUSSELL 47 ACT U
204 PHYSICIANS BLDG, COLUMBUS 31904
SIMMONS, JOHN W., III 22 ACT PD
4112 E PONCE DE LEON AVE, CLARKSTON 30021
SIMMONS, MACK 30 ACT GS
DOVER BLUFF CLUB 84, WAVERLY 31565
SIMMONS, ROBERT W. 76 ACT FP
1114 PROFESSIONAL BLVD, DALTON 30720
SIMMONS, WILLIAM C. 29 ACT P
1970 CLIFF VALLEY WAY NE, ATLANTA 30329
SIMONE, GREGORY L. 17 ACT CD
670 CHEROKEE ST, MARIETTA 30060
SIMPSON, HARVEY L. 61 ACT GS
1102 LAMAR ST, AMERICUS 31709
SIMPSON, MARSHALL A. 47 ACT P
2000 - 16TH AVE, COLUMBUS 31901
SIMPSON, MICHAEL T. 68 ACT CD,IM
BOX 1169, LA GRANGE 30241
SIMPSON, WALTER W. 47 ACT EM
5127 YOSEMITE DR, COLUMBUS 31907
SIMS, FAYETTE A., JR. 13 R GP
488 GWINNETT DR, LAWRENCEVILLE 30245
SIMS, HARRY EDWARD 36 ACT
PO BOX 955, FT VALLEY 31030
SIMS, J.P. 70 ACT FP
1 THOMAS RD, FT OGLETHORPE 30742
SIMS, JAMES A. 11 ACT AN
RTE 5 BOX 125 JS, COVINGTON LA 70433
SIMS, MICHAEL COOLIDGE 47 ACT US
2100 NORTH AVE, COLUMBUS 31904
SIMS, STUART E. 29 ACT GS
PO BOX 7800, ATLANTA 30357
SINCLAIR, CARTER A. 47 ACT FP
PO BOX 951, COLUMBUS 31994
SINGER, ARTHUR G. 60 ACT R
800 EAST DOYLE ST, TOCCOA 30577
SINGH, MANJIT 54 ACT GE
VA HOSPITAL MEDICAL CENTER, AUGUSTA 30910
SINGLETARY, ELIZABETH A. 54 ACT IM
MEDICAL COLLEGE OF GEORGIA, AUGUSTA 30912
SISSON, WILLIAM H. 11 ACT P
PO BOX 23089, SAVANNAH 31403
SISTRUNK, T.LEWIS 17 ACT R
600 WEST MEMORIAL DR, DALLAS 30132
SIZEMORE, JULIAN J., JR. 47 ACT PD
808 21ST ST, COLUMBUS 31904
SKANDALAKIS, JOHN E. 29 ACT GS
35 COLLIER RD NW, ATLANTA 30309
SKARDASIS, GEORGE M. 29 ACT CDS
25 PRESCOTT ST NE, ATLANTA 30308
SKEEL, OAVID A. 17 ACT U
2550 WINDY HILL RD STE 310, MARIETTA 30067
SKELTON, C.B. 03 ACT FP
802 EAST BROAD ST, WINDER 30680
SKELTON, LANA S. 30 ACT IM
3212 SHRINE RD, BRUNSWICK 31520
SKELTON, MARVIN E. 30 ACT R
3010 HAMPTON AVE, BRUNSWICK 31523
SKELTON, W. DOUGLAS 22 ACT P
PO BOX AF, ATLANTA 30322
SKINNER, JAMES M. 59 ACT OBG
610 SOUTH EIGHTH ST, GRIFFIN 30223
SKINNER, JOHN J., JR. 42 R IM
606 ACADEMY AVE, DUBLIN 31021
SKIPWORTH, GEORGE B. 47 ACT D
410 DOCTORS BLDG, COLUMBUS 31901
SKLAR, ALLAN H. 54 ACT IM,NEP
MEDICAL COLLEGE OF GEORGIA, AUGUSTA 30912
SKOBBA, JOSEPH S. 29 ACT P
2386 DELLWOOD DR, ATLANTA 30305
SLAOE, JOHN D. 29 ACT IM
768 JUNIPER ST NE, ATLANTA 30308
SLAPPEY, EOWIN D. 06 ACT OBG
770 PINE ST STE 360, MACON 31208
SLATE, ROBERT W. 60 ACT GS
PO BOX 609, TOCCOA 30577
SLAUGHTER, HOWEL W., JR. 29 ACT CHP
1935 CLIFF VALLEY WAY NE, ATLANTA 30329
SLAUGHTER, WILLIAM G. 65 ACT P
228 GORDON AVE, THOMASVILLE 31792
SLOAN, WYMAN P., III 29 ACT IM
340 BOULEVARD NE STE 324, ATLANTA 30312
SLUTSKY, MORTON 29 ACT PS
993-C JOHNSON FERRY RD NE, ATLANTA 30342
SMAHA, JERRY JOSEPH 06 ACT R
888 PINE ST, MACON 31201
SMILEY, DAVID T. 29 ACT OTO
3250 HOWELL MILL RD, ATLANTA 30327
SMILEY, F. JONES 70 ACT OBG
1816 LAFAYETTE RD, FT OGLETHORPE 30742
SMISSON, HUGH F. 06 ACT NS
740 HEMLOCK ST, MACON 31201
SMITH, AMOS A. 54 ACT AN
PO BOX 2765, AUGUSTA 30904
SMITH, ARTHUR A. 29 R OBG
3524 PRINCE GEORGE ST, EAST POINT 30344
SMITH, ARTHUR M. 54 ACT U
MEDICAL COLLEGE OF GEORGIA, AUGUSTA 30912
SMITH, BRUCE A. 23 ACT PD
419 FOURTH AVE, ALBANY 31701
SMITH, C. MORGAN, JR. 05 ACT FP
PO BOX 338, FITZGERALD 31750
SMITH, C.C. 54 ACT D
1345 DRUID PARK AVE, AUGUSTA 30904
SMITH, CARL A. 29 ACT AN
35 LINDEN AVE NE, ATLANTA 30308
SMITH, CARTER 29 ACT IM
35 COLLIER RD NW, ATLANTA 30309
SMITH, CARTER, JR. 29 ACT IM
35 COLLIER RD NW, ATLANTA 30309
SMITH, CHARLES M. 27 ACT FP
530 HUNTER ST, ROCKMART 30153
SMITH, CHARLES W. 29 ACT OBG
57 SIXTH ST NE, ATLANTA 30308
SMITH, CHRISTOPHER CAMPBELL 23 I&R GS
500 MEADOWLARK DR, ALBANY 31707
SMITH, DARIUS A. 17 ACT FP
625 WEST MEMORIAL DR, DALLAS 30132
SMITH, OAVIO H. 11 ACT PS
11706 MERCY BLVD #8, SAVANNAH 31406
SMITH, OENNIS B. 54 ACT N
VA HOSPITAL, AUGUSTA 30904
SMITH, DIANE K. 54 ACT IM
MEDICAL COLLEGE OF GA BD 101, AUGUSTA 30912
SMITH, DON T. 66 ACT FP
BOX 1348, TIFTON 31794
SMITH, DOUGLAS 22 ACT ORS
1405 CHURCH ST, DECATUR 30030
SMITH, E.G., JR. 29 R R
35 LINDEN AVE NE, ATLANTA 30308
SMITH, EDWARD H., JR. 54 ACT D
1021-15TH ST, AUGUSTA 30901
SMITH, F.A., JR. 42 ACT FP
PO BOX 477, MCRAE 31055
SMITH, FRANK Q. 56 ACT OBG
PO BOX 2748, VALDOSTA 31604
SMITH, FRED C. 56 ACT GS
101 WEST NORTHSIDE DR, VALDOSTA 31602
SMITH, GARY L. 17 ACT OBG
1230 JOHNSON FERRY RD D-10, MARIETTA 30067
SMITH, GEORGE BERTLING 47 ACT IM
2300 MANCHESTER EXPY, COLUMBUS 31904
SMITH, GEORGE L. 48 ACT
PO BOX 1557, COVINGTON 30209
SMITH, GREGORY VINCENT 34 ACT PD
1208 SHERWOOD PARK NE, GAINESVILLE 30501
SMITH, H. RANDOLPH 08 ACT FP
412 NORTHSIDE DR E, STATESBORO 30458
SMITH, H.W. 25 ACT OBS
PO BOX 160, SWAINSBORO 30401
SMITH, HENRY BRIGGS 56 ACT OTO
DOCTORS BLDG, VALDOSTA 31602
SMITH, HENRY M. 15 ACT N
2090 PRINCE AVE, ATHENS 30606
SMITH, HILTON E. 47 ACT FP
2300 MANCHESTER EXPY, COLUMBUS 31904
SMITH, J. DORSEY 08 ACT FP
PO BOX 538, METTER 30439
SMITH, J. GRAHAM 54 ACT D
MEDICAL COLLEGE OF GEORGIA, AUGUSTA 30912
SMITH, JAMES D. 11 ACT OBG
2 MEDICAL ARTS CENTER, SAVANNAH 31405
SMITH, JAMES E. 42 ACT GS
508 ACADEMY AVE, DUBLIN 31021

SMITH, JAMES FERRIS, JR. 06 ACT IM
729 PINE ST, MACON 31201
SMITH, JAMES L. 15 ACT OBG
740 PRINCE AVE, ATHENS 30601
SMITH, JAMES O., JR. 02 ACT FP
521 WEST MONTGOMERY ST, MILLEOGEVILLE 31061
SMITH, JAMES W. 45 ACT FP
129 EAST SECOND ST, MANCHESTER 31816
SMITH, JERRY O. 15 ACT R
ST MARYS HOSPITAL, ATHENS 30613
SMITH, JOEL P., JR. 29 ACT OTO
573 WEST PEACHTREE ST NE, ATLANTA 30308
SMITH, JOHN M. 30 ACT IM
PO BOX 1059, ST SIMONS IS 31522
SMITH, LEO 72 ACT OTO
1507 ST MARYS DR, WAYCROSS 31501
SMITH, LUCIUS S. 27 ACT R
FLOYO HOSPITAL, ROME 30162
SMITH, LUTHER J., II 47 ACT P
1953 SEVENTH AVE, COLUMBUS 31904
SMITH, MALCOLM M. 42 ACT FP
PO BOX 115, MCRAE 31055
SMITH, MARTIN H. 34 ACT PD
274 ENOTA DR NE, GAINESVILLE 30505
SMITH, MILLEDGE GLENN 30 ACT FP
3012 SHRINE RD, BRUNSWICK 31520
SMITH, NORMAN JOE 06 ACT ORS
380 HOSPITAL OR STE 125, MACON 31201
SMITH, PATTON P. 06 ACT FP
235 MEOICAL CT, FORSYTH 31029
SMITH, R. LOUIE 54 ACT GE
1514 ANTHONY RD, AUGUSTA 30904
SMITH, R.L. 50 ACT FP
455 PEACOCK ST, COCHRAN 31014
SMITH, RANDOLPH R. 54 ACT PS
820 ST SEBASTIAN WAY, AUGUSTA 30902
SMITH, REGINALD D. 29 A IM
2855 CANOLER RO STE 6, OECATUR 30034
SMITH, REUBEN J. 15 ACT OBG
740 PRINCE AVE, ATHENS 30601
SMITH, RICHARD A., MD (11) 29 ACT NS
35 COLLIER RO NW, ATLANTA 30309
SMITH, RICHARO B. 29 ACT PO
5675 PEACHTREE-OUNWOOOY RO, ATLANTA 30342
SMITH, RICHARD C. 70 ACT FP
PO BOX 967, LAFAYETTE 30728
SMITH, RICHARO NOEL 29 ACT TS
5667 PEACHTREE OUNWOOOY RD, ATLANTA 30342
SMITH, ROBERT B., III 29 ACT GS
1365 CLIFTON RD NE, ATLANTA 30322
SMITH, ROBERT C. 72 ACT R
PO BOX 938, WAYCROSS 31501
SMITH, ROBERT E. 27 ACT FP
302 TURNER MCCALL BLVD, ROME 30161
SMITH, ROBERT R. 68 R GS
BOX 725, CLAYTON 30525
SMITH, ROBERT W., III 29 ACT IM
478 PEACHTREE ST NE, ATLANTA 30308
SMITH, ROBLEY D. 66 ACT FP
PO BOX 788, TIFTON 31794
SMITH, RODNEY L. 34 ACT PTH
743 SPRING ST, GAINESVILLE 30505
SMITH, ROGER D. 42 ACT OPH
BELLEVUE RD, DUBLIN 31021
SMITH, SAMUEL R. 17 ACT AN
507 S KEELER WOODS DR, MARIETTA 30064
SMITH, STANLEY T., JR. 54 ACT
820 ST SEBASTIAN WAY, AUGUSTA 30904
SMITH, STEPHEN O. 27 ACT PD
10 HORSELEG CREEK RO, ROME 30163
SMITH, STUART A. 27 ACT OTO
15 JOHN MADDOX DR, ROME 30161
SMITH, THEODORE 59 ACT OBG
PO BOX 3877, JACKSON 30233
SMITH, THOMAS F. 29 ACT PD,AL
69 BUTLER ST SE, ATLANTA 30303
SMITH, THOMAS H., JR. 56 ACT OPH
3024 NORTH PATTERSON ST, VALOOSTA 31602
SMITH, TYSON D., JR. 48 ACT PTH
5126 HOSPITAL DR, COVINGTON 30209
SMITH, W.P. 10 ACT GS
PO BOX 630, BOWOON 30108
SMITH, W.T. 02 ACT P
CENTRAL STATE HOSPITAL, MILLEOGEVILLE 31062
SMITH, WILLIAM C. 70 ACT FP
2007 OLD LAFAYETTE RD, FT OGLETHORPE 30742
SMITH, WILLIAM P., JR. 22 ACT IM
4231 REOAN RO, STONE MOUNTAIN 30083
SMITH, WILLIAM S. 29 ACT OTO
490 PEACHTREE ST STE 347-B, ATLANTA 30308
SMITH, WILLIAM V. 59 ACT OBG
503 SOUTH EIGHTH ST, GRIFFIN 30223
SMOAK, HUBERT W., JR. 54 ACT AN
VA MEDICAL CENTER, AUGUSTA 30910
SNITZER, JOSEPH A., III 29 ACT PO
3162 PIEDMONT RD NE, ATLANTA 30305
SNYOER, WILLARD A. 30 ACT FP
2700 PARKWOOO OR, BRUNSWICK 31523
SO, ELSON L. 54 ACT N
VA MEDICAL CENTER, AUGUSTA 30910
SODER, PARRY D. 29 ACT R
5665 PEACHTREE-DUNWOODY NE, ATLANTA 30342
SOLODAR, SEYMOUR O. 17 ACT P
3985 SOUTH COBB DR STE 200, SMYRNA 30080
SOLSONA, CARLOS R. 13 ACT GS
2151 FOUNTAIN DR ' 102-A, SNELLVILLE 30278
SOMEREN, AYTEN 29 A PTH
80 BUTLER ST SE, ATLANTA 30303
SOMEREN, TUNCER 29 ACT NEP
25 PRESCOTT ST NE, ATLANTA 30308
SOMERLOT, WARREN A. 17 ACT OBG
643 CAMPBELL HILL ST, MARIETTA 30060
SOMERS, WILLIAM H. 06 R R
2881 INGLESIDE AVE, MACON 31204
SOMMERVILLE, MARGARET J. 29 ACT FP
90 WEST WIEUCA RD NE, ATLANTA 30342
SOMOGYI, JAMES W. 29 ACT R,NM
50 LULLWATER PL, ATLANTA 30307
SONES, PETER J. 29 ACT DR
1364 CLIFTON RD NE, ATLANTA 30322
SOOD, PRAN N. 16 ACT ORS
4939 RIVERDALE RD STE 100, ATLANTA 30337
SORACCO, GERARDO J. 29 ACT TS
1311 EAST CLEVELANO AVE, EAST POINT 30344
SORKEY, DAVIO 47 ACT CHP
2000 - 16TH AVE, COLUMBUS 31901
SORSDAHL, OLIVER A. 29 ACT OR
300 BOULEVARD NE, ATLANTA 30312
SOSBY, JOHN T. 20 ACT OBG
215 JACKSON ST, NEWNAN 30264
SOUMA, JOHN A. 06 ACT OBG
PO BOX 6000, MACON 31208
SOUTHER, JOE C. 03 ACT FP
802 EAST BROAD ST, WINOER 30680
SOUZA, RENATO C. 38 ACT EM
274 SENOIA RD, FAIRBURN 30213
SOWELL, OAVID S. 29 ACT GP
3580 ATLANTA AVE, HAPEVILLE 30354
SPANGLER, DENNIS LEE 17 ACT A
2480 WINDY HILL RD STE 201, MARIETTA 30067
SPANIER, JACOB A. 29 ACT OBG
315 BOULEVARD NE STE 328, ATLANTA 30312
SPANJER, RAYMOND F. 76 ACT FP
7400 SW 209 COURT RD, DUNNELLON FL 32630
SPANJER, RICHARD F. 76 ACT PD
1109 BURLEYSON DR, DALTON 30720
SPANN, CHARLES G. 65 ACT AN
1321 GORDON AVE, THOMASVILLE 31792
SPEAR, J. LOUIS 34 ACT R
2354 ISLAND DR NE, GAINESVILLE 30501
SPEARMAN, WILLIAM B. 29 ACT IM
1938 PEACHTREE RO NW STE 705, ATLANTA 30309
SPEARS, ROBERT S. 20 ACT AN
60 HOSPITAL RO, NEWNAN 30263
SPEARS, WENTFORD A. 36 ACT OTO
212 HOSPITAL DR STE C, WARNER ROBINS 31093
SPECTOR, ROBERT H. 29 ACT N,OPH
1365 CLIFTON RO NE, ATLANTA 30322
SPEIR, WILLIAM A., JR. 54 ACT PUO
1120-15TH ST, AUGUSTA 30912
SPERIOSU, SIMON V. 11 ACT P
1202 BRIGHTWOOD OR, SAVANNAH 31406
SPERK-BARD, EVA 47 ACT PTH
PO BOX 7000, COLUMBUS 31995
SPIEGL, PAUL V. 29 ACT ORS
5667 PEACHTREE-DUNWOODY RO, ATLANTA 30342
SPIER, GEORGE E. 20 ACT AN
80 JACKSON ST, NEWNAN 30263
SPIVEY, HERMAN E. 27 ACT FP
PO BOX 409, SUMMERVILLE 30747
SPIVEY, JAMES W. 36 ACT ORS
124 HOSPITAL OR, WARNER ROBINS 31093
SPIVEY, JIMMY A. 36 ACT ORS
124 HOSPITAL OR, WARNER ROBINS 31056
SPIVEY, OSCAR S. 06 ACT PO
1550 COLLEGE ST, MACON 31201
SPOTTSWOOD, PAUL G. 75 ACT AN
PO BOX 408, JESUP 31545
SPRINGER, JACK S. 17 ACT FP
2903 RIVERMEADE DR, ATLANTA 30327
SPROUSE, JAMES H., JR. 17 ACT AN
PO BOX 7449, MARIETTA 30065
SPRUELL, WILLIAM H. 22 ACT RHU
2712 NORTH OECATUR RD, DECATUR 30033
SREERAM, K.M. 06 ACT TS
700 SPRING ST, MACON 31201
SRIVASTAVA, RAMESH K. 15 ACT PS
1077 BAXTER ST, ATHENS 30606
ST. AMANT, WILLIAM C. 14 ACT EM
RT JONES HOSPITAL, CANTON 30114
ST. CLAIR, JANE T. 29 ACT AN
20 LINOEN AVE, ATLANTA 30308
ST. LOUIS, JOSEPH A., JR. 29 ACT OPH
275 CARPENTER OR, ATLANTA 30328
ST. PIERRE, RICK K. 29 I&R ORS
80 BUTLER ST SE, ATLANTA 30303
STAATS, ETHAN F. 29 ACT OTO
35 COLLIER RO NW, ATLANTA 30309
STACY, L. DAVID 29 ACT PTH
5665 PEACHTREE-DUNWOOOY RD, ATLANTA 30342
STAFFORD, CHARLES R. 34 ACT
254 SOUTH ENOTA DR, GAINESVILLE 30501
STAFFORD, CHARLES T. 21 ACT OBG
1323 EAST SHOTWELL ST, BAINBRIOGE 31717
STAHL, LOREN C. 06 ACT IM
618 ORANGE ST, MACON 31201
STAIMAN, RICHARD I. 08 ACT PTH
PO BOX 1048, STATESBORO 30458
STALEY, IRVING T. 17 ACT OPH
653 CHEROKEE ST, MARIETTA 30060
STALLINGS, WILLIAM P., JR. 29 ACT D
2732-A FELTON OR, EAST POINT 30344
STAMEY, CHARLES C. 47 ACT OBG
629-20TH ST, COLUMBUS 31904
STAMPS, EDWARD ROE 06 R U
643 ORANGE ST, MACON 31201
STANCIL, MELODY ANN 68 ACT AN
1555 OOCTORS OR, LA GRANGE 30240
STANLEY, CASSIUS M., III 06 ACT U
673 PINE ST, MACON 31201
STANLEY, THOMAS M. 11 ACT N
5105 PAULSEN ST STE 111, SAVANNAH 31405
STANTON, PAUL E., JR. 29 ACT GS
315 BOULEVARO NE, ATLANTA 30312
STAPLETON, GERALD M. 17 ACT OTO
1790 MULKEY RD STE 7, AUSTELL 30001
STAPLETON, JAMES W. 42 S ORS
2309 SCOTT DR, OUBLIN 31021

STAPLETON, JOHN L. 47 ACT U
2846 COLLEGE DR, COLUMBUS 31901
STAPLETON, SIDNEY L., JR. 29 ACT CDS
340 BOULEVARD NE, ATLANTA 30312
STAPLETON, TOMMY K. 18 ACT FP
PO BOX 769, DOUGLAS 31533
STAPPENBECK, RICHARD A. 16 ACT N
237 MEDICAL WAY, RIVERDALE 30274
STAR, FRANKLIN J. 47 ACT GS
905 CENTER ST, COLUMBUS 31901
STARGEL, MICHAEL D. 29 ACT PTH
5665 PEACHTREE DUNWOODY RD, ATLANTA 30342
STARLING, ROBERT J. 21 ACT FP
611 MORRIS AVE, DONALSONVILLE 31745
STARR, DONALD C. 11 ACT R
311 EAST HALL ST, SAVANNAH 31401
STARR, HARLAN M. 27 ACT PD
16 HOSPITAL CIR, ROME 30161
STARR, TRAMWELL, III 27 ACT PUD
1825 MARTHA BERRY BLVD, ROME 30161
STATHAM, GEORGE W. 22 ACT PD
4112 E PONCE DE LEON AVE, CLARKSTON 30021
STATON, GERALD W., JR. 29 ACT PUD
25 PRESCOTT ST NE, ATLANTA 30365
STATON, JEAN STEWART 22 ACT IM
2754 N DECATUR RD STE 112, DECATUR 30033
STATON, TED L. 29 ACT U
340 BOULEVARD NE #409, ATLANTA 30312
STEADMAN, HENRY E. 29 ACT GS
340 BOULEVARD NE STE 304, ATLANTA 30312
STEBLER, MICHAEL E. 72 ACT PTH
MEMORIAL HOSPITAL, WAYCROSS 31501
STEED, WILLIAM A. 54 ACT OTO
1122 DRUID PARK AVE, AUGUSTA 30904
STEELE, BYRON H. 31 ACT FP
PO BOX 128, FAIRMOUNT 30139
STEELE, JOHN C.H., JR. 54 ACT PTH
MEDICAL COLLEGE OF GEORGIA, AUGUSTA 30912
STEFANIS, GEORGE S. 06 ACT NS
3 BACONSFIELD PK STE 80, MACON 31211
STEFANSSON, STURLA 06 ACT AN
777 HEMLOCK ST, MACON 31201
STEGALL, FRANK D. 27 ACT CD
HARBIN CLINIC, ROME 30161
STEGEMAN, JOHN F. 15 R IM
1010 PRINCE AVE, ATHENS 30601
STEIN, J.D. 47 ACT AN
404 DOCTORS BLDG, COLUMBUS 31901
STEINBERG, DAVID L. 29 ACT IM
5669 PEACHTREE-DUNWOODY RD, ATLANTA 30342
STEINBERG, JAMES P. 29 ACT IM
1297 OAKDALE RD NE, ATLANTA 30307
STEINER, ALBIN H. 61 ACT R
701 EAST LAMAR ST, AMERICUS 31709
STEINHAUS, JOHN E. 29 ACT AN
1365 CLIFTON RD NE, ATLANTA 30322
STELLER, ROBERT T. 19 ACT OPH
2907 SOUTH MAIN ST, MOULTRIE 31768
STELLING, HENRY G. 06 I&R OBG
118 DEERWOOD CIR, WARNER ROBINS 31093
STEM, WILLIAM C. 04 ACT ORS
156 MCEVER ST STE 4, CARTERSVILLE 30120
STEPHENS, DAN B. 17 ACT OBG
140 VANN ST STE 300, MARIETTA 30060
STEPHENS, DAVID B. 06 ACT TS
770 PINE ST, MACON 31201
STEPHENS, J.RONALD 29 ACT GS
478 PEACHTREE ST NE, ATLANTA 30308
STEPHENS, MARVIN R. 34 ACT AN
743 SPRING ST, GAINESVILLE 30505
STEPHENS, ROBERT O. 17 ACT PD
833 CAMPBELL HILL ST ' 112, MARIETTA 30090
STEPHENSON, CHARLES W. 70 ACT FP
PO BOX 580, RINGGOLD 30736
STEPHENSON, JOHN R. 47 ACT ORS
2009 WARM SPRINGS RD, COLUMBUS 31904
STEPHENSON, ROBERT E., III 22 ACT DR
755 COLUMBIA DR STE 205, DECATUR 30030
STEPHENSON, ROBERT H. 29 ACT GS
3250 HOWELL MILL RD NW #204, ATLANTA 30327
STERGUS, INGRID 27 ACT PTH
316 MOUNT ALTO RD, ROME 30161
STEVENS, EDWARD L. 06 ACT OTO
800 FIRST ST, MACON 31201
STEVENSON, CHARLES E., JR. 10 ACT PD
523 DIXIE ST STE 7, CARROLLTON 30117
STEVES, ELMA M. 22 ACT PD
3624 CHAMBLEE-TUCKER RD, CHAMBLEE 30341
STEWART, BETTY G. 56 ACT P,N
PO BOX 1804, VALDOSTA 31601
STEWART, CALVIN B. 29 ACT GS
103 TARRAGON CT, FRANKLIN TN 37064
STEWART, CHARLES C. 21 ACT FP
PO BOX 128, DONALSONVILLE 31745
STEWART, CHARLES P., JR. 29 ACT CHP
2151 PEACHFORD RD, ATLANTA 30338
STEWART, DEANNA B. 17 ACT PD
833 CAMPBELL HILL ST ' 270, MARIETTA 30090
STEWART, DONALD M. 47 ACT AN
404 DOCTORS BLDG, COLUMBUS 31901
STEWART, J. BENHAM 06 ACT GS
700 SPRING ST, MACON 31201
STEWART, RICHARD M. 34 ACT IM
660-B LANIER PARK DR NE, GAINESVILLE 30501
STICH, JOHN W. 68 ACT PTH
PATHOLOGY DEPARTMENT, LA GRANGE 30240
STILL, JOSEPH M., JR. 54 ACT PS
PO BOX 3726, AUGUSTA 30904
STINCER, ELPIDIO F. 02 ACT P
CENTRAL STATE HOSPITAL, MILLEDGEVILLE 31061
STINCER, ELPIDIO J. 54 ACT IM
3623 J DEWEY GRAY CIR STE D, AUGUSTA 30909
STIVERS, ROBERT R. 29 ACT PTH
50 COCA-COLA PL SE, ATLANTA 30303
STOCKS, S. ALLAN 54 ACT OPH
1514 ANTHONY RD, AUGUSTA 30904
STOCKSTILL, J. DEAN 47 I&R
PO BOX 951, COLUMBUS 31994
STODDARD, LELAND D. 54 ACT PTH
MEDICAL COLLEGE OF GEORGIA, AUGUSTA 30912
STOKES, J. JACK 29 ACT OPH
3280 HOWELL MILL RD NW, ATLANTA 30327
STONE, ALBERT LAWRENCE 16 ACT PD
1035 MAIN ST, FOREST PARK 30050
STONE, CHARLES F., JR. 29 ACT IM
35 COLLIER RD NW, ATLANTA 30309
STONE, JAMES H. 23 ACT FP
2202 EAST OGLTHORPE, ALBANY 31705
STONE, LAWRENCE B. 29 ACT R
1000 JOHNSON FERRY RD NE, ATLANTA 30342
STONE, R.L. 11 R AN
5737 COLONIAL DR, SAVANNAH 31406
STONE, WILLIAM D. 29 ACT FP
478 PEACHTREE ST STE 722-A, ATLANTA 30365
STONER, CYRUS H. 29 ACT OPH
5200 LONG ISLAND DR NW, ATLANTA 30327
STOREY, GEORGE M. 61 ACT ORS
629 EAST FORSYTH ST, AMERICUS 31709
STORY, FRANK CRAWFORD, JR. 54 ACT OBG
1505 WINTER ST, AUGUSTA 30904
STORY, JAMES L., JR. 65 ACT GS
505 GORDON AVE, THOMASVILLE 31792
STORY, STACY H., III 54 ACT AN
BOX 3881 HILL STA, AUGUSTA 30909
STOUDEMIRE, G. ALAN 29 ACT P
BOX 3903, DURHAM NC 27710
STOUT, ALAN W. 47 I&R
PO BOX 951, COLUMBUS 31994
STOVALL, RUSSELL H., JR. 22 ACT OTO
484 IRVIN CT STE 140, DECATUR 30030
STRESE, FRITZ W. 65 ACT FP
ARCHBOLD MEM HOSPITAL, THOMASVILLE 31792
STRIBLING, WARREN D. 34 ACT IM
710 BROAD ST SE, GAINESVILLE 30501
STRICKLAND, AVERY W. 30 ACT IM
3010 HAMPTON AVE, BRUNSWICK 31520
STRICKLAND, SAMUEL L. 23 ACT DR
PO BOX 1924, ALBANY 31703
STRICKLAND, W.E. 36 ACT OBG
1119 MORNINGSIDE DR, PERRY 31069
STRICKLER, C.W., JR. 29 ACT IM
212 TOWNSEND PL NW, ATLANTA 30327
STRICKLER, D.T., JR. 32 ACT FP
PO BOX 519, DOUGLASVILLE 30133
STRINGER, EDWARD F. 11 ACT GS
#1 MEDICAL ARTS CENTER, SAVANNAH 31405
STRITTMATTER, JAMES C. 34 ACT R,NM
PO BOX 2417, GAINESVILLE 30503
STROM, CARL H. 22 ACT FP
5040 SNAPFINGER WOODS DR, DECATUR 30035
STRONG, WILLIAM B. 54 ACT PDC
MEDICAL COLLEGE OF GEORGIA, AUGUSTA 30912
STROPNICKY, ELIZABETH 76 ACT OBG
1108 PROFESSIONAL BLVD, DALTON 30720
STROUP, DAVID G. 29 ACT OBG
1311 EAST CLEVELAND AVE, EAST POINT 30344
STRUTH, ALAN G. 36 ACT IM
PO BOX 2405, WARNER ROBINS 31093
STUART, CARLOS A. 29 ACT IM
1938 PEACHTREE RD NW STE 705, ATLANTA 30309
STUART, WILLIAM H. 29 ACT IM
105 COLLIER RD NW, ATLANTA 30309
STUBBS, JOE C. 56 ACT IM
101 NORTHSIDE DR, VALDOSTA 31602
STUBBS, JOSEPH T., JR. 11 ACT OPH
PO BOX 14608, SAVANNAH 31406
STUBBS, JOSEPH W. 23 ACT IM
PO BOX 288, ALBANY 31703
STUBBS, O. WYTCH, JR. 22 ACT FP
1462 MONTREAL RD #303, TUCKER 30084
STUCK, ROBERT G. 48 ACT ORS
5303 ADAMS ST NE, COVINGTON 30209
STUCKEY, ANN D. 59 ACT PD
718 SOUTH EIGHTH ST, GRIFFIN 30223
STUCKEY, KATHERINE 22 ACT AN
727 KENILWORTH CIR, STONE MOUNTAIN 30083
STUMP, ROBERT L., JR. 56 ACT FP
1624 BOONE DR, VALDOSTA 31602
STURKIE, THOMAS OTIS 17 ACT ORS
652 CHURCH ST, MARIETTA 30060
STURM, HIRAM MAXWELL 29 ACT D
1938 PEACHTREE RD NW, ATLANTA 30309
SU, SHAW C.T. 11 ACT U
PO BOX 14459, SAVANNAH 31406
SUAREZ, ALFREDO E. 01 ACT GP
205 NORTH BOULEVARD, BAXLEY 31513
SUAREZ, RAMON A. 29 ACT OBG
105 COLLIER RD NW STE 2030, ATLANTA 30309
SUBER, HUBERT 57 ACT OBG
PO BOX 30, VIDALIA 30474
SUGRUE, MARJORIE L. 36 ACT GP
105 CALLE VERDE, WARNER ROBINS 31093
SUIT, JAMES I. 06 ACT OPH
626 FIRST ST, MACON 31098
SULLIVAN, CARY E. 29 ACT PD
2555 CUMBERLAND PKY, ATLANTA 30339
SULLIVAN, DANIEL B. 54 ACT GS
1430 HARPER ST, AUGUSTA 30902
SULLIVAN, HUMBERT G. 54 ACT NS
MEDICAL COLLEGE OF GEORGIA, AUGUSTA 30912
SULLIVAN, JAMES H. 47 ACT U
1021 TALBOTTON RD, COLUMBUS 31904
SULLIVAN, LOUIS W. 29 ACT IM
720 WESTVIEW DR SW, ATLANTA 30310
SULLIVAN, ROBERT F. 28 ACT US
10 ROYSTON RD, CARNESVILLE 30521
SUMERS, KAREN D. 29 ACT OPH
3280 HOWELL MILL RD STE 207, ATLANTA 30329

SUMMEROUR, BROOKE F. 76 ACT AN
821 ATKINSON DR, DALTON 30720
SUMMERS, ROLAND S. 11 ACT IM,PUD
PO BOX 23677, SAVANNAH 31403
SUNG, YUNG-FONG 29 ACT AN
EMORY UNIVERSITY HOSPITAL, ATLANTA 30322
SUSSMAN, HY C. 54 ACT IM
820 ST SEBASTIAN WAY SE, AUGUSTA 30902
SUTLIVE, WILLIAM G. 11 ACT OBG
5420 PAULSEN ST, SAVANNAH 31405
SUTTER, LUTHER O. 76 ACT FP
PO BOX 709, CHATSWORTH 30705
SUTTON, JAMES MACK, JR. 23 ACT PD
412 FOURTH AVE, ALBANY 31701
SUTTON, JEFFREY L. 17 ACT IM
833 CAMPBELL HILL ST ' 230, MARIETTA 30090
SWAIN, BRUCE 33 ACT FP
CLARKESVILLE 30523
SWANN, JULIAN W. 29 ACT D
478 PEACHTREE ST #1007, ATLANTA 30308
SWANN, R.WADE, JR. 30 ACT D
3215 SHRINE RD, BRUNSWICK 31520
SWARTOUT, JOSEPH R. 06 ACT OBG
1400 COLEMAN AVE, MACON 31207
SWEAT, MAXWELL J., JR. 23 ACT PD
2609 EAST DOUBLEGATE DR, ALBANY 31707
SWIFT, JONATHAN S. 17 ACT ORS
754 CHEROKEE ST, MARIETTA 30060
SWIFT, THOMAS R. 54 ACT N
MEDICAL COLLEGE OF GEORGIA, AUGUSTA 30912
SWINGLE, ROGER L. 15 ACT ORS
125 KING AVE, ATHENS 30610
SWINT, ROBERT H. 08 ACT GS
PO BOX 1088, STATESBORO 30458
SYMBAS, PETER 29 ACT TS
69 BUTLER ST SE, ATLANTA 30303
SYN, WAI YUN 22 ACT IM
1462 MONTREAL RD, TUCKER 30084
SYRIBEYS, JOHN P. 22 ACT GS
3576-A CHAMBLEE-TUCKER RD, CHAMBLEE 30341
SZECSEY, ALEXANDER 29 ACT OBG
1245 ALPHARETTA ST, ROSWELL 30075

T

TABATABAI, JAFAR 22 ACT FP
1039 THIRD ST, STONE MOUNTAIN 30083
TAFFEL, BRUCE H. 29 ACT OBG
993-D JOHNSON FERRY RD NE, ATLANTA 30042
TAIT, C. DOWNING, JR. 29 ACT P
3400 PEACHTREE RD NE, ATLANTA 30326
TAKAGI, LUIS RAUL 16 ACT OBG
189 MEDICAL WAY STE B, RIVERDALE 30274
TAKLE, LEIV M. 59 ACT OPH
646 SOUTH EIGHTH ST, GRIFFIN 30223
TALBOTT, G. DOUGLAS 22 ACT IM
3985 SOUTH COBB DR STE 210, SMYRNA 30080
TALLEDO, O. EDUAROO 54 ACT OBG
MEDICAL COLLEGE OF GEORGIA, AUGUSTA 30904
TALLEY, DEAN B. 10 ACT IM
523 DIXIE ST #5, CARROLLTON 30117
TALLEY, J. LECONTE, JR. 23 ACT OBG
901 NORTH MADISON ST, ALBANY 31705
TALLEY, JOEL D., III 22 I&R IM
1750-13 CLAIRMONT RD, DECATUR 30033
TALLEY, WILLIAM STEELE 29 A PH
4770 NORTH PEACHTREE RD, ATLANTA 30338
TALLMAN, JAMES M. 17 ACT R
814 HAMPTON PL, MARIETTA 30064
TALMAOGE, HARRY E. 15 ACT GS
1077 BAXTER ST, ATHENS 30606
TAMAYO, ELMO R. 76 ACT FP
OLD ELLIJAY RD, CHATSWORTH 30705
TAMAYO, PEDRO L. 02 ACT ORS
750 NORTH COBB ST, MILLEDGEVILLE 31061
TAN, CARLOS Y. 11 ACT GS,GP
4 POOLER PROF PL, POOLER 31322
TAN, JOSEFINA C. 11 ACT GP,AN
PO BOX 38, GUYTON 31312
TAN, MIKE Y. 16 ACT AN
233 PLANTATION DR, RIVERDALE 30296
TANENBAUM, MARC A. 29 ACT PD
6667 VERNON WOODS DR NE, ATLANTA 30328
TANKESLEY, ROBERT M. 71 R R
PO BOX 982, MONTREAT NC 28757
TANNER, DAVID D. 29 ACT AL
1938 PEACHTREE ST NW STE 507, ATLANTA 30309
TANNER, DAVID E. 11 ACT R
PO BOX 23089, SAVANNAH 31403
TANNER, GEORGE E. 42 ACT GS
ERIN OFFICE PARK, DUBLIN 31021
TANNER, JACK E. 17 ACT OBG
1200 ROSWELL RD, MARIETTA 30062
TANNER, JAMES C., JR. 29 R GS
1180 MOUNT PARAN RD NW, ATLANTA 30327
TANNER, MAURICE B. 65 ACT R
PO BOX 736, THOMASVILLE 31792
TANNER, ROBERT E. 54 ACT PD
3520 WALTON WAY, AUGUSTA 30909
TAORMINA, FRANK E. 56 ACT CDS
PO BOX 3132, VALDOSTA 31601
TAPIA, RENE A. 22 ACT PTH
2701 NORTH DECATUR RD, DECATUR 30033
TARABADKAR, SANJIWAN V. 06 ACT AN
PO BOX 6000, MACON 31210
TARANTO, ALAN I. 29 ACT IM
993-D JOHNSON FERRY RD NE, ATLANTA 30342
TARANTO, MORRIS B. 29 ACT FP
478 PEACHTREE ST NE #107-A, ATLANTA 30308
TARCAN, YAVUZ A. 29 ACT NM,IM
1364 CLIFTON RD NE, ATLANTA 30322
TARK, MARVIN D. 17 ACT AN
833 CAMPBELL HILL ST #460, MARIETTA 30090
TATE, JOHN D. 27 ACT FP
14 HOSPITAL CIR, ROME 30161
TATUM, JOSEPH C. 22 ACT ORS
1405 CHURCH ST, DECATUR 30030
TATUM, L.L, JR. 59 ACT U
653 SOUTH EIGHTH ST, GRIFFIN 30223
TAUBE, TITUS A. 50 ACT FP
104 EAST DYKES ST, COCHRAN 31014
TAUBER, CHARLES P. 29 ACT P
1218 WEST PACES FERRY RD NW, ATLANTA 30327
TAUBER, HARVEY B. 29 ACT U
5667 PEACHTREE DUNWOODY RD, ATLANTA 30342
TAUNTON, W. STEPHEN 06 ACT FP
100 CULLODEN RD, FORSYTH 31029
TAYLOR, CHARLES D. 34 ACT IM
710 BROAD ST SE, GAINESVILLE 30501
TAYLOR, DAVID M. 29 ACT IM
340 BOULEVARD NE STE 214, ATLANTA 30312
TAYLOR, GERALD J. 61 ACT P
712 EAST FORSYTH, AMERICUS 31709
TAYLOR, HOWARD P. 30 ACT FP,OBG
PO DRAWER 855, SEA ISLAND 31561
TAYLOR, JAMES P. 65 ACT OBG
507 GORDON AVE, THOMASVILLE 31792
TAYLOR, JAMES W. 72 ACT OPH
304 RIVERSIDE DR, WAYCROSS 31501
TAYLOR, JOHN EDWIN, JR. 22 ACT PD
4112 E PONCE DE LEON AVE, CLARKSTON 30021
TAYLOR, NEILL O. 61 ACT OBG
205 SOUTH LEE ST, AMERICUS 31709
TAYLOR, ROBERT P. 17 ACT OPH
833 CAMPBELL HILL ST #380, MARIETTA 30090
TAYLOR, TERRY W. 29 ACT OPH
993-F JOHNSON FERRY RD NE, ATLANTA 30342
TAYLOR, THOMAS B. 32 ACT US
PO BOX 698, DOUGLASVILLE 30134
TAYLOR, WARREN A. 65 ACT GS
PROF BLDG SIEXAS ST, THOMASVILLE 31792
TAYLOR, WILLIAM E. 74 I&R FP
PO BOX 386, TENNILLE 31089
TAYLOR, WILLIAM J. 29 ACT FP
2049 PERKERSON RD SW, ATLANTA 30310
TEAFORD, HENRY S., JR. 61 ACT GS
BOX 787, AMERICUS 31709
TEATE, H. LUTEN, JR. 22 ACT PD
1901 CENTURY BLVD NE #20, ATLANTA 30345
TEDESCO, FRANCIS JOSEPH 54 ACT GE
MEDICAL COLLEGE OF GEORGIA, AUGUSTA 30901
TEEM, MARTIN V., JR. 17 ACT IM
200 CHEROKEE ST, MARIETTA 30060
TEKIN, MAHIR 38 ACT AN
490 WEST PACES FERRY RD NW, ATLANTA 30305
TEMPLES, POWELL M., JR. 29 DE4 P
145-15TH ST NE, ATLANTA 30361
TEMPLETON, H. WAYNE 17 ACT FP
4755 KELLY CT, MABLETON 30059
TEPLIS, PAUL 29 ACT IM
3250 HOWELL MILL RD NW, ATLANTA 30327
TERMOTTO, DAVID WALTER 17 ACT AN
3530 BRIARCLIFF RD NE, ATLANTA 30345
TERRELL, WARREN 70 ACT AN
PO BOX 10, ROSSVILLE 30741
TERRY, DANIEL B., JR. 72 ACT FP
1508 TEBEAU ST, WAYCROSS 31501
TERRY, THOMAS L. 06 ACT IM,CD
618-B ORANGE ST, MACON 31201
TERRY, WILLIAM H. 06 ACT IM
3 BACONSFIELD OFC PK STE 2, MACON 31201
TETHER, ROBERT S. 34 ACT GS
194 GOLD ST NE, GAINESVILLE 30505
TEUTSCH, CAROL B. 22 ACT END
484 IRVIN CT STE 240, DECATUR 30030
THAGARD, ROY FRANK 30 ACT PD
2927 DEMERE RD, ST SIMONS IS 31522
THAKRAR, B.D. 33 ACT GS
PO BOX 307, DEMOREST 30535
THAKRAR, CHANDRIKA B. 33 ACT AN
PO BOX 307, DEMOREST 30535
THAMES, FRANK MAYNARD, JR. 23 ACT DR
PO BOX 1924, ALBANY 31703
THEBAUT, BEN R. 29 R GS
226 THE SOUTH CHASE, ATLANTA 30328
THERIOT, GEORGIA M. 06 I&R FP
784 SPRING ST, MACON 31201
THEUS, THOMAS L. 47 ACT IM
PHYSICIANS BLDG, COLUMBUS 31901
THIBODEAUX, DAVID C. 17 ACT R
70 TOWER RD NW, MARIETTA 30060
THIGPEN, CORBETT M. 54 ACT ORS
HUMANA MEDICAL PLAZA STE 210, AUGUSTA 30909
THITARAM, SOMPHONG 29 ACT GS
2351 BOLTON RD NW #116, ATLANTA 30318
THOMAS, BOBBY MATHEW 15 ACT R
1230 BAXTER ST, ATHENS 30613
THOMAS, BRENDA H. 72 ACT PD
307 PINEVIEW DR, WAYCROSS 31501
THOMAS, CHARLES 15 ACT GS
1010 PRINCE AVE, ATHENS 30606
THOMAS, DAVID M. 11 ACT OBG
36 MEDICAL ARTS CENTER, SAVANNAH 31405
THOMAS, DAVID R., III 54 ACT PUD
820 SAN SEBASTIAN WAY ' 2-B, AUGUSTA 30902
THOMAS, DENNIS R. 66 ACT FP
PO BOX 711, ADEL 31620
THOMAS, DONALD RAY 76 ACT FP
1714 CLEVELAND RD, DALTON 30720
THOMAS, FRANK E. 23 ACT PD
2419 EAST ALBERSON DR, ALBANY 31707
THOMAS, FRED B., JR. 34 ACT PS
1224 SHERWOOD PARK DR NE, GAINESVILLE 30501
THOMAS, JERRY L. 47 I&R
PO BOX 951, COLUMBUS 31994
THOMAS, KENNETH E. 29 ACT TS,CDS
5669 PEACHTREE-DUNWOODY RD, ATLANTA 30342

THOMAS, LUTHER M., JR. 54 ACT IM
1500 JOHNS RD, AUGUSTA 30904
THOMAS, RUSSELL 61 ACT GP
LESLIE RD, AMERICUS 31709
THOMAS, W. KEVIN 29 ACT OPH
5675 PEACHTREE-DUNWOODY RD, ATLANTA 30342
THOMASSON, JAMES J., JR. 20 ACT GS
PO BOX 609, NEWNAN 30263
THOMPSON, ALBERT M., JR. 29 A AM,FP
2797 CAMPBELLTON RD STE B-1, ATLANTA 30311
THOMPSON, CAROL G. 29 ACT P
1935 CLIFF VALLEY WAY #225, ATLANTA 30329
THOMPSON, CLEVELAND, III 72 ACT GS
303 PINEVIEW DR, WAYCROSS 31501
THOMPSON, D.O. 29 ACT FP
478 PEACHTREE ST NE, ATLANTA 30308
THOMPSON, EMORY F. 56 ACT OPH
PO BOX 3193, VALDOSTA 31601
THOMPSON, F.H. 61 ACT PTH
712 EAST FORSYTH ST, AMERICUS 31709
THOMPSON, HUGH S., JR. 29 ACT ORS
PO DRAWER T, EAST POINT 30344
THOMPSON, JACK A. 29 ACT GS
1938 PEACHTREE RD NW, ATLANTA 30309
THOMPSON, JAMES W. 15 ACT IM
1010 PRINCE AVE, ATHENS 30601
THOMPSON, JOHN D. 29 ACT OBG
16 PRESCOTT WALK NE, ATLANTA 30307
THOMPSON, JOHN W. 29 ACT PD
101 WEST WESLEY ST, WALHALLA SC 29691
THOMPSON, RAMON C. 15 ACT U
225 SOUTH MILLEDGE AVE, ATHENS 30601
THOMPSON, ROBERT E. 60 ACT FP
800 EAST DOYLE ST, TOCCOA 30577
THOMPSON, ROBERT F. 20 ACT OTO
PO BOX 1155, NEWNAN 30263
THOMPSON, W. JACKSON 34 ACT GYN
1144 VINE ST NE, GAINESVILLE 30505
THOMPSON, WILLIAM A. 65 ACT OBG
706 SOUTH BROAD ST, THOMASVILLE 31792
THOMPSON, WILLIAM R. 31 ACT GP
MEDICAL ARTS CENTER, CALHOUN 30701
THORNE, OARLENE C. 11 ACT PTH
11705 MERCY BLVD, SAVANNAH 31406
THORNELOE, WILLIAM F. 29 ACT P
490 PEACHTREE ST NE, ATLANTA 30308
THORNTON, H.A. 49 ACT FP
PO BOX 326, GREENSBORO 30642
THORNTON, NANCY 11 ACT PD
108-A BUTLER AVE, TYBEE ISLAND 31328
THORNTON, NATHANIEL A. 29 ACT IM
1938 PEACHTREE RD NW STE 705, ATLANTA 30309
THRASHER, BARRIE H., JR. 29 ACT OPH
3280 HOWELL MILL RD NW #207, ATLANTA 30327
THRELKELD, WILLIAM A. 56 ACT P
PO BOX 1727, VALDOSTA 31601
THRONE, MARTIN L. 29 ACT IM
4536 CHAMBLEE-DUNWOODY RD, ATLANTA 30338
THURMAN, LAVON, JR. 47 ACT FP
2121 WARM SPRINGS RD, COLUMBUS 31904
THURMONO, A.G. 54 ACT OBG
1012 CAROLINA AVE APT 4, N AUGUSTA SC 29841
THURMONO, GEORGE W. 54 ACT OTO
2283 WRIGHTSBORO RD, AUGUSTA 30904
THURMOND, J.W. 54 ACT OBG
849 OLD EDGEFIELD RD, N AUGUSTA SC 29841
THWAITE, WALTER G. 29 R OBG
927 OAKDALE RD NE, ATLANTA 30307
TIDMORE, THOMAS L., JR. 29 ACT AN
1405 CLIFTON RD NE, ATLANTA 30322
TIDWELL, REX W. 06 ACT R
380 HOSPITAL DR, MACON 31201
TIDWELL, THOMAS J. 22 ACT R,ON
2701 NORTH DECATUR RD, DECATUR 30033
TIFT, HENRY H. 06 ACT IM
765 SPRING ST, MACON 31201
TILIACOS, JOHN N. 17 ACT ORS
127 CHERRY ST, MARIETTA 30060
TILLERY, WILLIAM V., III 54 ACT OPH
1514 ANTHONY RD, AUGUSTA 30904
TILLINGER, ARNOLD J. 11 ACT P
515 EAST 63RD ST, SAVANNAH 31405
TILLMAN, BILLUPS P. 15 ACT ORS
125 KING AVE, ATHENS 30601
TILLMAN, RALPH A. 22 ACT OBG
5040 SNAPFINGER WOODS DR, DECATUR 30035
TILLMAN, SAMUEL P. 08 ACT IM
302 DONEHOO ST, STATESBORO 30458
TILSON, PAUL J. 08 ACT U
422 NORTHSIDE DR E, STATESBORO 30458
TIMBERLAKE, LLOYD F. 29 ACT IM
35 COLLIER RD NW, ATLANTA 30309
TIMMS, OICKY W. 11 ACT GS
9-A MEDICAL ARTS CENTER, SAVANNAH 31405
TINDALL, GEORGE T. 22 ACT NS
1365 CLIFTON RD, ATLANTA 30322
TINDALL, SUZIE C. 22 ACT NS
80 BUTLER ST SE, ATLANTA 30303
TINKELMAN, DAVID G. 17 ACT A
2480 WINDY HILL RD #201, MARIETTA 30067
TIPPINS, WILLIAM C., JR. 22 ACT OBG
5040 SNAPFINGER WOODS DR, DECATUR 30035
TISON, JAMES H. 50 ACT IM
717 GRIFFIN ST, EASTMAN 31023
TKALYCH, GEORGE P. 47 ACT OTO,HNS
2039 TENTH AVE, COLUMBUS 31901
TODD, CHARLES E., JR. 29 ACT GS
35 COLLIER RD NW, ATLANTA 30309
TOOINO, JOEL O. 27 ACT IM
11 JOHN MADDOX DR, ROME 30161
TODMANN, DEXTER T. 29 A IM
401 WEST PEACHTREE ST NE, ATLANTA 30308
TOLER, EARLE Q. 29 ACT IM
2981 CHURCH ST, EAST POINT 30344
TOLLISON, JOSEPH W. 54 ACT FP
MEDICAL COLLEGE OF GEORGIA, AUGUSTA 30902
TOMEH, M.O. 29 ACT PD
2758 FELTON DR, EAST POINT 30344
TOMLINSON, RONALD L. 72 ACT U
BOX 2007, WAYCROSS 31501
TONG, KUN YUAN 23 ACT OBG
420 FOURTH AVE, ALBANY 31701
TOOLE, JAMES C. 17 ACT OBG
643 CAMPBELL HILL ST, MARIETTA 30060
TOOLE, WILLIAN NISBET 29 ACT U
6500 VERNON WOODS RD NE, ATLANTA 30328
TOOTLE, GEORGE S. 13 ACT GS
PO BOX 35, DULUTH 30136
TOOTLE, JERRY C. 13 ACT GS
PO BOX 746, DULUTH 30136
TOPOROFF, STUART J. 29 ACT CD
5665 PEACHTREE-DUNWOODY RD, ATLANTA 30342
TORAYA, JULES 11 ACT OBG
2512 HABERSHAM ST, SAVANNAH 31401
TORNOW, ABRAHAM M. 29 S IM
1436 BRIARCLIFF RD NE, ATLANTA 30306
TORRANCE, CLARENCE B. 22 ACT PD
4536 CHAMBLEE-DUNWOODY RD, ATLANTA 30338
TORRES, SAMUEL A. 11 ACT U
PO BOX 14459, SAVANNAH 31406
TORRES, WILLIAM E. 22 ACT R
1365 CLIFTON RD NE, ATLANTA 30322
TOVAR-DE-HOYOS, MANUEL 56 ACT FP
301 WOODROW WILSON DR, VALDOSTA 31602
TOWNSEND, DALE J. 29 S OS
PO BOX 499, PALMETTO 30268
TOWNSEND, ROBERT M. 17 ACT FP
110 LEWIS DR, MARIETTA 30060
TRACHT, ARTHUR L. 22 ACT ORS
497 WINN WAY STE A-260, DECATUR 30030
TRAER, JON W. 74 ACT GS
522 WASHINGTON AVE, SANDERSVILLE 31082
TRAIN, JOHN KIRK, JR. 11 ACT OTO
23 EAST 65TH ST, SAVANNAH 31405
TRAN, CHUONG D. 54 ACT GP
3504 POTOMAC DR, AUGUSTA 30906
TRAYLOR, JAMES BOTHWELL 15 R OBG
175 ROCK GLENN RD, ATHENS 30606
TRAYLOR, S.B. 59 ACT FP
MAIN ST, BARNESVILLE 30204
TREADWELL, TANOY W., JR. 06 ACT FP
784 SPRING ST, MACON 31201
TREST, FRED A. 54 ACT P
2322 WRIGHTSBORO RD, AUGUSTA 30904
TRIANA, CARLOS R. 72 ACT GS
PO BOX 337, PATTERSON 31557
TRICE, JOHN C. 15 ACT P
PO BOX 6105, ATHENS 30604
TRINCHER, ROSE C. 54 ACT IM
VA MEDICAL CENTER, AUGUSTA 30904
TRIPP, JOHN N. 06 ACT FP
MERCER UNIV SCHOOL OF MED, MACON 31207
TRIPPE, JUDSON R., JR. 17 ACT PD
833 CAMPBELL HILL ST ' 112, MARIETTA 30090
TRITT, RAMIE ABRAHAM 29 ACT OTO
960 JOHNSON FERRY RD STE 350, ATLANTA 30342
TROPAUER, ALAN 29 ACT P
STE 400, ATLANTA 30305
TROTTER, JOHN F. 22 ACT FP
484 IRVIN CT STE 110, DECATUR 30030
TRULOCK, ALBERT S., JR. 23 ACT GS
800 NORTH JEFFERSON ST, ALBANY 31701
TRYON, WILLIAM E. 17 ACT FP
1323-A ROSWELL RD, MARIETTA 30062
TSAO, SHU-YUN T. 15 ACT PD
1077 BAXTER ST, ATHENS 30606
TUCK, G.G. 48 ACT FP
PO BOX 1058, COVINGTON 30209
TUCKER, JOHN O. 17 ACT GS
805 CAMPBELL HILL ST, MARIETTA 30090
TUCKER, JOHN P. 19 R FP
704 THIRD ST SW, MOULTRIE 31768
TUCKER, R.P. 29 ACT GS
1603 WARE AVE, EAST POINT 30344
TUCKER, THOMAS S. 29 ACT IM
6500 VERNON WOODS DR STE A2, ATLANTA 30328
TUGGLE, M. VIRGINIA 22 ACT IM
1336 COLUMBIA DR, DECATUR 30032
TULEY, CATHLEEN HARTMAN 16 ACT EM
PO BOX 314, RIVERDALE 30274
TULEY, R. OAVID 16 ACT GS
33 SW UPPER RIVERDALE RD, RIVERDALE 30274
TUMLIN, WILLIAM O. 15 ACT FP
CRAWFORD LEXINGTON MED CTR, LEXINGTON 30648
TURCOTTE, MAURICE R. 29 ACT AN
2760-B FELTON DR, EAST POINT 30344
TURK, L. NEWTON, III 29 ACT TS
35 COLLIER RD NW, ATLANTA 30309
TURK, L.N., JR. 37 ACT GS
PO BOX 52, HOMER 30547
TURNER, AUGUST B. 29 ACT GS
384 PEACHTREE ST NE, ATLANTA 30308
TURNER, CORBETT H. 29 ACT CHP
1711 UPPERGATE DR NE, ATLANTA 30307
TURNER, DANIEL R. 22 ACT IM
755 COLUMBIA DR STE 618, DECATUR 30030
TURNER, DAVIO A. 23 ACT P
PO BOX 1828, ALBANY 31703
TURNER, DON W. 22 ACT P
2905 PEACHTREE RD NE, ATLANTA 30305
TURNER, H. LEONARO, JR 22 ACT IM
1275 MCCONNELL DR, DECATUR 30033
TURNER, H.H. 47 ACT IM
ST FRANCIS MEDICAL PARK, COLUMBUS 31904
TURNER, J.R. 68 ACT IM
115 CHURCH ST, LA GRANGE 30240
TURNER, JOHN S., JR. 29 ACT OTO
EMORY UNIVERSITY CLINIC, ATLANTA 30322

TURNER, JOHN W. 29 ACT GS
3985 VERMONT RD NE, ATLANTA 30319
TURNER, JOSEPH M. 66 ACT IM
PO BOX 947, TIFTON 31794
TURNER, RICHARD J. 60 ACT FP
PO BOX 746, CLAYTON 30525
TURRENTINE, JOHN E. 29 ACT OBG
35 COLLIER RD NW STE 230, ATLANTA 30309
TURRENTINE, PAUL E. 29 ACT OBG
35 COLLIER RD NW, ATLANTA 30309
TUTEN, CARROLL 30 ACT OPH
3011 KEMBLE AVE, BRUNSWICK 31520
TYLER, HERBERT D. 69 ACT IM
PO BOX 710, THOMASTON 30286
TYLER, RICHARD M. 29 A ORS
338 WEST PEACHTREE ST NE, ATLANTA 30308
TYRONE, NELSON O., JR. 47 ACT U
2300 MANCHESTER EXPY BLDG C, COLUMBUS 31904

U

UDEL, MELVIN M. 17 ACT P,PM
3985 SOUTH COBB DR STE 110, SMYRNA 30080
ULLMAN, KARL H. 29 ACT IM
1311 CLEVELAND AVE, EAST POINT 30344
UMPIERRE, JORGE E. 17 ACT PD
833 CAMPBELL HILL ST ' 360, MARIETTA 30090
UNDERWOOD, CHARLES R. 17 ACT GS
641 CHURCH ST, MARIETTA 30060
UNDERWOOD, FRANK O. 29 ACT DR
1968 PEACHTREE RD NW, ATLANTA 30309
UNTERMAN, MARC I. 13 ACT CD
719 SCENIC HWY, LAWRENCEVILLE 30245
UPCHURCH, W.E. 29 ACT U
1774 ATWOOD RD NE, ATLANTA 30305
UPSHAW, CHARLES B., JR. 29 ACT CD
35 COLLIER RD NW, ATLANTA 30309
UPSON, E.T. 29 R GS
RTE 7 BOX 241, CUMMING 30130
URRUTIA, R.V., JR. 17 ACT ORS
3903 SOUTH COBB DR STE 101, SMYRNA 30080
URRUTIA, ROSA C. 17 ACT FP
3903 SOUTH DR #209, SMYRNA 30080
USHER, CHARLES, JR. 11 ACT NS
5354 REYNOLDS ST #519, SAVANNAH 31405
UTKE, ROONEY R. 48 ACT GP
2111 FLAT SHOALS RD STE 105, CONYERS 30208
UTLEY, HENRY G. 15 ACT OPH
500 NORTH MILLEDGE AVE, ATHENS 30601

V

VALBUENA, O.A. 11 ACT AN
9 TOMACHICHI LN, SAVANNAH 31411
VALDECANAS, VIRGILIO 02 ACT GS
750 NORTH COBB ST, MILLEDGEVILLE 31061
VALENTINE, H.E., JR. 34 ACT IM
429 SPRING ST SE, GAINESVILLE 30501
VAN BUREN, E. 29 ACT IM
870 CLIFTON RD NE, ATLANTA 30307
VAN BUREN, JAMES K. 29 ACT IM,PUD
490 PEACHTREE ST NE, ATLANTA 30308
VAN DE WATER, JOSEPH M. 06 ACT CD,TS
777 HEMLOCK ST, MACON 31201
VAN DE WETERING, R.J. 29 ACT P
5675 PEACHTREE-DUNWOODY RD, ATLANTA 30342
VAN DUYN, JOHN 47 ACT PS
6345 MOUNTAINVIEW DR, COLUMBUS 31904
VAN OYCK, PHILIP G. 15 ACT R
ATHENS GENERAL HOSPITAL, ATHENS 30613
VAN DYKE, PAUL B. 30 ACT FP
PO DRAWER N, BRUNSWICK 31521
VAN GIESEN, GEORGE E., JR. 54 ACT IM
1109 MEDICAL CENTER DR ' 4-C, AUGUSTA 30909
VAN HOUTEN, JOHN B., JR. 17 ACT GP
PO BOX 7449, MARIETTA 30065
VANCE, LUTHER, JR. 36 ACT FP
1057 MORNINGSIDE DR, PERRY 31069
VANDERPOOL, GERALD E. 29 ACT P
6667 VERNON WOODS DR NE, ATLANTA 30328
VANDERYT, WILLIAM J. 22 ACT ORS
1462 MONTREAL RD STE 114, TUCKER 30084
VANDERZALM, THEODORA 54 ACT R
MEDICAL COLLEGE OF GEORGIA, AUGUSTA 30912
VANOIVER, ROY W. 22 ACT NS
370 WINN WAY STE 201, DECATUR 30030
VANSANT, JOHNATHAN PAUL 47 ACT IM
2300 MANCHESTER EXPY, COLUMBUS 31904
VANSANT, T.J., JR. 17 ACT IM
702 CHEROKEE ST, MARIETTA 30060
VARGO, JAMES D. 29 ACT P
3985 SOUTH COBB DR, SMYRNA 30080
VARMA, JAYOEV R. 54 ACT FP
MEDICAL COLLEGE OF GEORGIA, AUGUSTA 30912
VARNADORE, J. GREG 60 ACT FP
PO BOX 1268, TOCCOA 30577
VARNAM, GERALD S. 17 ACT IM
PO BOX 105103, ATLANTA 30067
VARNER, JOHN B. 29 R OBG
1601 OCEAN DR S, JACKSONVILLE BCH FL 32250
VARNER, W.O. 47 ACT OBG
2300 MANCHESTER EXPY, COLUMBUS 31904
VASKO, TRUMAN L. 61 ACT GS
PO BOX 247, VIENNA 31092
VASSEY, GEORGE C. 70 R
25 S GERMANTOWN RD, CHATTANOOGA TN 37411
VAUGHAN, EOGAR ALLEN 17 ACT PD
74 MEDICAL SQ, MARIETTA 30060
VAUGHAN, R.H. 47 ACT GS
DOCTORS BLDG #211, COLUMBUS 31901
VAUGHAN, W.L. 44 ACT GS
PO BOX 1076, THOMSON 30824
VAZQUEZ, JOSEPH G. 58 ACT FP,EM
PO BOX 429, BLAKELY 31723
VEAL, CURTIS F. 02 ACT FP
PO BOX 489, MILLEDGEVILLE 31061
VEATCH, J.W., JR. 29 ACT GS
25 PRESCOTT ST NE, ATLANTA 30308
VECCHIO, JOHN J. 36 ACT U
212 HOSPITAL DR, WARNER ROBINS 31093
VELAZCO, ANTENOR 29 ACT ORS
2788 BAYARD ST STE 2102, EAST POINT 30344
VELKOFF, ABRAHAM S. 29 ACT OBG
1175 PEACHTREE ST NE, ATLANTA 30309
VENABLE, JAMES H. 47 ACT OBG
PHYSICIANS BLDG STE 104, COLUMBUS 31901
VENABLE, ROGER J. 54 ACT FP
1417 PENDLETON RD, AUGUSTA 30904
VERLEY, KARL W. 29 ACT OBG
384 PEACHTREE ST STE 205, ATLANTA 30308
VERNON, MINOR C. 06 ACT PD
770 PINE ST STE 350, MACON 31201
VERRAS, ATHANASIOS 22 ACT PD
2100 PARKLAKE DR NE, ATLANTA 30345
VIAMONTE, LUIS M. 76 ACT PD
BURLEYSON DR, DALTON 30720
VICKERS, OTIS R. 18 ACT GS
PO BOX 979, DOUGLAS 31533
VICKERY, S.A. 37 ACT FP
259 NORTH ELM ST, COMMERCE 30529
VICTOR, IRVING 11 ACT U
PO BOX 14459, SAVANNAH 31406
VICTOR, JULES, III 11 ACT IM,ON
PO BOX 14359, SAVANNAH 31406
VICTOR, JULES, JR. 11 ACT IM
PO BOX 14359, SAVANNAH 31406
VICTOR, SAMUEL 72 ACT FP
1010 SEMINOLE TR, WAYCROSS 31501
VILLANUEVA, LUDOVICO S. 29 ACT P
5840 ALLEN CT NE, SANDY SPRINGS 30328
VINSON, FRANK 36 ACT FP
725 NORTH MACON ST, FORT VALLEY 31030
VINSON, T.O. 22 R PH
1480 RAINIER FALLS DR NE, ATLANTA 30329
VISINTINE, AAROLYN M. 29 A PD
4647 CLUB VALLEY DR NE, ATLANTA 30319
VOGLER, WILLIAM R. 22 ACT HEM
1365 CLIFTON RD, ATLANTA 30322
VOHMAN, MANN O. 29 ACT PTH
1968 PEACHTREE RD NW, ATLANTA 30309
VOLJAVEC, BOZIDAR F. 29 ACT IM
1311 CLEVELAND AVE, EAST POINT 30344
VOLPITTO, P.P. 54 ACT AN
TALMADGE MEMORIAL HOSPITAL, AUGUSTA 30902
VON OER LAGE, F.C., JR. 29 ACT AN
35 COLLIER RD NW STE 560, ATLANTA 30309
VON HAAM, EMMERICH, JR. 29 ACT ORS
2788 BAYARD ST, EAST POINT 30344
VOSS, CRAIG A. 27 ACT PTH
321 TURNER MCCALL BLVD, ROME 30161
VOYLES, WALTER R. 09 ACT GS
307 FOURTH ST, WAYNESBORO 30830
VRANA, MARK 15 ACT IM
1199 PRINCE AVE, ATHENS 30606

W

WADE, JIM R. 60 ACT IM
800 EAST DOYLE ST, TOCCOA 30577
WADE, JOHN S. 11 ACT GS
22 MEDICAL ARTS CENTER, SAVANNAH 31405
WADE, ROBERT C. 22 R FP
798 RAYS RD, STONE MOUNTAIN 30083
WAOE, THOMAS ANDREW, JR. 47 ACT IM
1005 TALBOTTON RD, COLUMBUS 31904
WAGES, HARVEY S., JR. 76 ACT OBG
1109 BURLEYSON DR STE A, DALTON 30720
WAGES, TOM L. 13 ACT FP
BUFORD MEDICAL CLINIC, BUFORD 30518
WAGGONER, OAVID C. 29 ACT P
PO BOX 52645, ATLANTA 30355
WAGNER, GEORGE C. 26 ACT IM
PO BOX 1194, CORDELE 31015
WAGSTAFF, JAMES L. 48 ACT R,NM
3848 TAWNY BIRCH CT, DECATUR 30034
WAITS, EOWARD JONES 29 ACT GS
960 JOHNSON FERRY RD NE, ATLANTA 30342
WAKEFIELO, JOHN R. 17 R FP
4900 TIMBERLAND DR, MABLETON 30059
WALDEMAYER, E.W. 61 ACT FP
3222 BARKSIDE CT, CHAMBLEE 30341
WALDEN, CHARLES W. 22 ACT P
1462 MONTREAL RD STE 216, TUCKER 30084
WALOREP, JACK MARION 27 ACT U
101 JOHN MADDOX DR, ROME 30161
WALDROP, JOHN I. 47 ACT ORS
6262 HAMILTON RD, COLUMBUS 31904
WALKER, BEVERLY O. 23 ACT PD
311 SECOND AVE, ALBANY 31701
WALKER, C.J., JR. 34 ACT FP
242 ENOTA DR NE, GAINESVILLE 30505
WALKER, CHARLES O. 21 ACT GS
PO BOX 1805, BAINBRIDGE 31717
WALKER, DON C. 20 ACT GS
58 HOSPITAL RD STE 102, NEWNAN 30263
WALKER, DUNCAN, JR. 06 ACT OTO
700 SPRING ST, MACON 31201
WALKER, EXUM B. 29 ACT NS
490 PEACHTREE ST STE 570-C, ATLANTA 30308
WALKER, GARY K. 06 ACT PTH
MEDICAL CENTER OF CENTRAL GA, MACON 31208
WALKER, GEORGE L. 59 R IM
330 EAST COLLEGE ST APT 106, GRIFFIN 30223
WALKER, GEORGE S., III 50 ACT IM
107 PROFESSIONAL CTR DR, EASTMAN 31023

WALKER, JAMES A. 22 ACT U
755 COLUMBIA DR 'B, DECATUR 30030
WALKER, JEROME M., JR. 22 ACT N
370 WINN WAY STE 101, DECATUR 30030
WALKER, JOHN W. 22 ACT OBG
465 WINN WAY STE 150, DECATUR 30030
WALKER, KNOX, JR. 22 ACT ORS
PO BOX 1517, DECATUR 30030
WALKER, MARY E. 22 R PD
RTE 7 HOLLAND RD, CUMMING 30130
WALKER, PRICE, JR. 47 ACT IM,HEM
PO BOX 9516, COLUMBUS 31908
WALKER, R. JEFFREYS, III 29 ACT R
172 ATLANTA COUNTRY CLUB DR, MARIETTA 30067
WALKER, ROBERT J., JR. 06 ACT PH
779 DOWNING ST, MACON 31204
WALKER, W.W., III 22 ACT OBG
365 WINN WAY STE 140, DECATUR 30030
WALL, SCOT A. 23 ACT OPH
2308 PALMYRA RD, ALBANY 31701
WALLACE, BILL L. 17 ACT FP
2480 WINDY HILL RD, MARIETTA 30067
WALLACE, DOUGLAS W. 47 ACT R
PO BOX 2787, COLUMBUS 31907
WALLACE, ROBERT G. 47 ACT R
PO DRAWER 2787, COLUMBUS 31902
WALLACE, RUSSELL W., JR. 22 ACT N
370 WINN WAY STE 104, DECATUR 30030
WALLACE, STANLEY W. 29 ACT IM,CD
3995 LAWRENCEVILLE HWY, LILBURN 30247
WALLACE, STUART M. 11 ACT PTH
PO BOX 22007, SAVANNAH 31403
WALLER, JOHN L. 29 ACT AN
1364 CLIFTON RD NE, ATLANTA 30322
WALLER, ROBERT D. 23 ACT R
PO BOX 1924, ALBANY 31703
WALLER, ROY M., JR. 47 ACT OBG
PHYSICIANS BLDG, COLUMBUS 31901
WALLNER, HERMAN W. 47 ACT P
2000 16TH AVE, COLUMBUS 31901
WALTER, JONNE B. 29 ACT PUD
340 BOULEVARD NE STE 315, ATLANTA 30312
WALTER, R.D. 31 ACT FP
SOUTH WALL ST, CALHOUN 30701
WALTERS, GORDON E. 54 ACT IM
1500 JOHNS RD, AUGUSTA 30904
WALTERS, STEVEN L. 17 ACT GS
805 CAMPBELL HILL ST, MARIETTA 30060
WALTON, KENNETH N. 29 ACT U
1365 CLIFTON RD NE, ATLANTA 30322
WALUS, MICHAEL A. 76 ACT NS
1207 MOICE DR, DALTON 30720
WALZ, PETER D. 22 ACT IM
2054-B LAWRENCEVILLE HWY, DECATUR 30033
WAMMOCK, HOKE 68 ACT GS
ENOCH CALLAWAY CANCER CNTR, LA GRANGE 30240
WAMMOCK, VIRGENE S. 68 ACT D
771 LAKEWOOD DR, LA GRANGE 30240
WARD, BRADLEY L. 27 ACT FP
PO BOX 130, TAYLORSVILLE 30178
WARD, CHARLES J. 22 ACT OBG
365 WINN WAY STE 140, DECATUR 30030
WARD, CHARLES M. 53 ACT FP
303 JOHNSON ST, DAWSON 31742
WARD, DANIEL F. 54 ACT EM
MEDICAL COLLEGE OF GEORGIA, AUGUSTA 30912
WARD, EUGENE L. 34 ACT OTO
PO BOX 13, GAINESVILLE 30503
WARD, JOHN A. 29 S IM
1670 CLAIRMONT RD NE, DECATUR 30033
WARD, JOHN R. 74 ACT GS
522 WASHINGTON AVE, SANDERSVILLE 31082
WARD, M. CAROLYN 17 ACT OBG
652 CHURCH ST STE D, MARIETTA 30060
WARD, M. TERRY 29 A EM
2980 PONDVIEW CT, MARIETTA 30062
WARD, NORMAN S. 14 ACT FP
PO BOX 1038, CANTON 30114
WARD, RICHARD S. 22 ACT P
1711 UPPERGATE DR NE, ATLANTA 30307
WARD, TIMOTHY H. 65 ACT AN
211 GREENLEAF TERR, THOMASVILLE 31792
WARE, CHARLES I. 33 ACT GYN
PO BOX G, CLARKSVILLE 30523
WARE, J. PATRICK 29 ACT CHP
2531 BRIARCLIFF RD STE 216, ATLANTA 30329
WARE, JOHN R. 10 ACT IM
523 DIXIE ST, CARROLLTON 30117
WARING, GEORGE O. 22 ACT OPH
1365 CLIFTON RD NE, ATLANTA 30322
WARKENTIN, JOHN 29 ACT P
2905 PEACHTREE RD NE, ATLANTA 30363
WARNER, JOHN C., JR. 17 ACT PD
3001 SOUTH COBB DR SE, SMYRNA 30080
WARNOCK, RALPH PARKS 69 ACT FP
208 CHEROKEE RD, THOMASTON 30286
WARREN, H. RUDOLPH 29 ACT P
2151 PEACHFORD RD, ATLANTA 30338
WARREN, JAMES E. 17 ACT AN
PO BOX 7449, MARIETTA 30065
WARREN, W. DEAN 29 ACT GS
1364 CLIFTON RD NE, ATLANTA 30322
WASDEN, HOWELL A. 45 ACT FP
BOX 447, WARM SPRINGS 31830
WASHBURN, LAWRENCE, JR. 29 R P
4620 WIEUCA RD, ATLANTA 30342
WASSERMAN, STANLEY B. 29 A PD
99 BUTLER ST SE, ATLANTA 30303
WATERS, A.J. 54 ACT AN
3405 SASANQUA DR, AUGUSTA 30909
WATERS, BARBARA B. 10 ACT R
605 DIXIE ST, CARROLLTON 30117
WATERS, DONALD B. 72 ACT FP
PO BOX 369, BLACKSHEAR 31516
WATERS, LAMAR H. 33 ACT IM
BOX 228, CLARKESVILLE 30523
WATERS, RAYMOND O. 27 ACT OTO
15 JOHN MADDOX DR, ROME 30161
WATERS, WILLIAM C., III 29 ACT IM
35 COLLIER RD NW, ATLANTA 30309
WATKINS, CHARLES B. 22 ACT FP
3652 CHAMBLEE-DUNWOODY RD, CHAMBLEE 30341
WATKINS, LAURENCE O. 54 ACT IM
MEDICAL COLLEGE OF GEORGIA, AUGUSTA 30912
WATKINS, PATRICIA N. 54 ACT P
1220 GEORGE C WILSON DR, AUGUSTA 30909
WATKINS, W. LORRAINE 29 ACT PD
1935 CLIFF VALLEY WAY NE, ATLANTA 30329
WATSON, DAVID T. 29 ACT IM
35 COLLIER RD NW STE 500, ATLANTA 30309
WATSON, DAVIS R. 47 ACT OTO
PO BOX 4336, COLUMBUS 31904
WATSON, EDWIN R. 06 ACT PD
745 PINE ST, MACON 31201
WATSON, FRANCIS M., JR. 29 ACT ORS
1938 PEACHTREE RD NE STE 603, ATLANTA 30309
WATSON, JOHN D., JR. 47 ACT R
PO DRAWER 2787, COLUMBUS 31902
WATSON, W.G. 54 ACT OBG
1430 HARPER ST, AUGUSTA 30902
WATSON, WILLIAM W. 17 ACT EM
677 CHURCH ST, MARIETTA 30060
WATT, CHARLES H., JR. 65 ACT GS
900 GORDON AVE, THOMASVILLE 31792
WATT, JAMES A. 30 ACT P,PTH
PO DRAWER 1291, DARIEN 31305
WATT, WILLIAM V. 65 ACT GS,GE
900 GORDON AVE, THOMASVILLE 31792
WATTANAWANAKUL, SOMSAK 53 ACT R,GP
TERREL COUNTY HOSPITAL, DAWSON 31742
WATTERS, JULIAN Q. 29 R PD
4770 NORTH PEACHTREE RD NE, ATLANTA 30338
WATTS, JUBAL R. 10 ACT ORS
148 CLINIC AVE, CARROLLTON 30117
WATTS, MICHAEL A. 54 ACT TS
2100 CENTRAL AVE STE 5, AUGUSTA 30904
WAYNE, BARRY A. 47 I&R
PO BOX 951, COLUMBUS 31994
WEAVER, ALEXANDER H.S. 06 ACT ORS
870 HIGH ST, MACON 31201
WEAVER, JERRY O. 27 ACT FP
502 NORTH MAIN ST, CEDARTOWN 30125
WEAVER, LESLIE L. 31 ACT PTH
GORDON HOSPITAL, CALHOUN 30701
WEAVER, RICHARD J. 57 ACT PTH
PO BOX 1343, VIDALIA 30474
WEAVER, ROSE ANN RIGBY 49 ACT IM
172 NORTH MAIN ST, MADISON 30650
WEAVER, WILLIAM H.M. 06 ACT IM
700 SPRING ST, MACON 31201
WEBB, H. MICHAEL 36 ACT EM
BOX 2886, WARNER ROBINS 31093
WEBB, RAY D. 11 ACT GP
PO BOX 217, SPRINGFIELD 31329
WEBER, JONATHAN 17 ACT AN
833 CAMPBELL HILL ST ' 460, MARIETTA 30090
WEBSTER, PAUL D., III 54 ACT GE
MEDICAL COLLEGE OF GEORGIA, AUGUSTA 30912
WEBSTER, ROBERT M. 29 ACT IM,A
2665 ACADIA ST, EAST POINT 30344
WEEKS, RICHARD B. 54 ACT GS
4230-13TH ST, ST SIMONS IS 31522
WEEKS, WALLACE R. 76 ACT FP
1012 BURLEYSON DR, DALTON 30720
WEEMS, H.E., JR. 36 ACT FP
PO DRAWER G, PERRY 31069
WEENS, H.S. 29 ACT R
80 BUTLER ST SE, ATLANTA 30303
WEIDENHEIM, KAREN M. 22 I&R PTH
EMORY UNIVERSITY, ATLANTA 30322
WEINSTEIN, M. LOUIS 29 ACT DR
11585 ALPHARETTA ST, ROSWELL 30076
WEINSTEIN, MICHAEL N. 29 ACT IM
11050 CRABAPPLE RD STE 115D, ROSWELL 30075
WEISMAN, EVAN B. 17 ACT IM
833 CAMPBELL HIL ST, MARIETTA 30090
WEISS, HARVEY A. 29 ACT PS
993-D JOHNSON FERRY RD NE, ATLANTA 30342
WEISSMAN, EVELYN L. 39 ACT GS
1067 PEACHTREE ST, LOUISVILLE 30434
WEISSMAN, IRA M. 39 ACT PD
1067 PEACHTREE ST, LOUISVILLE 30434
WEKSLER, LUIZ 06 ACT AN
135 HINES TERR, MACON 31204
WELLBORN, ROGER G. 06 I&R FP
784 SPRING ST, MACON 31201
WELLS, CHARLES C., JR. 06 ACT N
829 FIRST ST, MACON 31201
WELLS, DAVID A. 76 ACT FP
1219 MEMORIAL DR, DALTON 30720
WELLS, JAMES M. 06 ACT AN
2983 VICTORIA DR, MACON 31201
WELLS, JOHN A. 06 ACT GS
700 SPRING ST, MACON 31201
WELLS, JOHN G. 20 ACT IM
PO BOX 1099, NEWNAN 30264
WELLS, PERRY B. 06 ACT OBG
770 PINE ST STE 360, MACON 31201
WELLS, PHILIP H. 29 ACT AN
5665 PEACHTREE-DUNWOODY RD, ATLANTA 30342
WELLS, ROBERT E. 29 ACT ORS
105 COLLIER RD NW STE 5000, ATLANTA 30309
WENER, JEFFREY ALLAN 17 ACT ORS
2550 WINDY HILL RD #304, MARIETTA 30067
WENER, ROBERT GORDON 17 ACT OPH
2550 WINDY HILL RD #303, MARIETTA 30067
WENGER, JULIUS 29 S IM
69 BUTLER ST, ATLANTA 30303

WENGER, NANETTE K. 29 A CD
69 BUTLER ST SE, ATLANTA 30303
WERNER, JACQUELINE H. 16 ACT PTH
11 SW UPPER RIVERDALE RD, RIVERDALE 30274
WESSINGER, WILLIAM N. 11 ACT ORS,HS
800 EAST 70TH ST, SAVANNAH 31405
WEST, J. MICHAEL 15 ACT GE
1077 BAXTER ST, ATHENS 30606
WEST, JOHN H. 11 ACT HEM,ON
PO BOX 23829, SAVANNAH 31403
WEST, JOHN THOMAS 68 ACT GS
301 MEDICAL DR ' 503/504, LA GRANGE 30240
WEST, ROBERT M. 29 ACT GP
1134 MAIN ST, FOREST PARK 30050
WEST, ROGER G. 29 I&R R
1364 CLIFTON RD NE, ATLANTA 30322
WESTFALL, DAVID N. 34 ACT FP
668 LANIER PARK DR NE, GAINESVILLE 30501
WESTON, WILLIAM, III 54 ACT PD
MEDICAL COLLEGE OF GEORGIA, AUGUSTA 30901
WETHERBY, DAVID 58 ACT
BOX 128 WASHINGTON ST, FT GAINES 31751
WHALEY, WILLIAM H. 29 ACT IM
3250 HOWELL MILL RD NW, ATLANTA 30327
WHATLEY, E.C. 36 ACT GP
PO BOX 367, REYNOLDS 31076
WHATLEY, JAMES C. 27 ACT IM
1825 MARTHA BERRY BLVD, ROME 30161
WHATLEY, LEWIS R. 04 ACT FP
38 GREEN ST, CARTERSVILLE 30120
WHEATLEY, JOSEPH K. 29 ACT U
1365 CLIFTON RD NE DEPT UROL, ATLANTA 30322
WHEELER, GEORGE B., III 30 ACT OBG
3020 SHRINE RD, BRUNSWICK 31520
WHEELER, JAMES H. 29 ACT FP,P
993-F JOHNSON FERRY RD NE, ATLANTA 30342
WHELAN, EDWARD J. 11 ACT U
720 EAST 66TH ST, SAVANNAH 31405
WHELCHEL, MERRITT C. 54 ACT OPH
905-15TH ST 'E, AUGUSTA 30902
WHERRY, RICHARD A. 43 ACT FP
96 MEMORIAL DR, DAHLONEGA 30533
WHIODER, OESIDERIUS C. 29 ACT GS
490 PEACHTREE ST, ATLANTA 30308
WHIDDON, C. MAURICE 11 ACT GS
22 MEDICAL ARTS CENTER, SAVANNAH 31405
WHIPPLE, STEPHEN B. 29 ACT P
1938 PEACHTREE RD NW, ATLANTA 30309
WHISNANT, CHARLES L., JR. 29 R IM
4760 TALL PINES DR NW, ATLANTA 30327
WHITAKER, CECIL F. 47 ACT OBG
629-20TH ST, COLUMBUS 31904
WHITAKER, JAMES Q. 36 ACT PTH
PO BOX 2343, WARNER ROBINS 31099
WHITAKER, WILLIAM G., III 22 ACT DR
755 COLUMBIA DR STE 205, DECATUR 30030
WHITAKER, WILLIAM G., JR. 29 ACT GS
35 COLLIER RD NW, ATLANTA 30309
WHITE, JEFFEORY H. 76 ACT PD
1217 MEMORIAL DR, DALTON 30720
WHITE, MICHAEL A. 48 ACT AN
258 GAITHER RD, MANSFIELD 30255
WHITE, PAUL C., JR. 23 ACT PH
1109 NORTH JACKSON ST, ALBANY 31701
WHITE, PERRY M. 29 R ORS
1547 CAVE RD NW, ATLANTA 30327
WHITE, STEPHEN R., MD FACS 08 ACT GS
412 NORTHSIDE DR, STATESBORO 30458
WHITE, WILLIAM H., JR. 34 ACT OBG
1100 VINE ST NE, GAINESVILLE 30505
WHITEHEAD, C. MARK 68 ACT U
303 SMITH ST, LA GRANGE 30240
WHITEHEAD, C. MARK, JR. 68 ACT U
303 SMITH ST, LA GRANGE 30240
WHITEHHURST, JOHN O. 47 ACT PS
PO BOX 7000, COLUMBUS 31995
WHITESIDES, THOMAS E., JR. 29 ACT ORS
EMORY UNIVERSITY CLINIC, ATLANTA 30322
WHITFIELD, T.W. 76 ACT FP
1221 MEMORIAL DR, DALTON 30720
WHITLOCK, PAUL A., JR. MD FACS 08 ACT GS
412 NORTHSIDE DRIVE, STATESBORO 30458
WHITLOCK, RICHARD R., JR. 54 ACT IM,CD
MEDICAL COLLEGE OF GEORGIA, AUGUSTA 30904
WHITMIRE, RONALD N. 34 ACT OTO
660-D LANIER PARK DR, GAINESVILLE 30505
WHITNEY, DOUGLASS G. 29 ACT CDS
993-F JOHNSON FERRY RD NE, ATLANTA 30342
WHITSON, THEODORE C. 22 ACT PS
365 WINN WAY STE 241, DECATUR 30030
WHITTLE, MICHAEL H. 19 ACT R
PO BOX 608, MOULTRIE 31768
WHITTLE, MICHAEL R. 23 ACT PTH
2800 NORTH DOUBLE GATE RD, ALBANY 31707
WHITWORTH, C.W. 34 ACT OTO
PO BOX 315, GAINESVILLE 30503
WHITWORTH, JACK W. 45 R FP
1901 NORTH SECOND CT, LANETT AL 36863
WHITWORTH, STEVEN R. 11 I&R GS
MEMORIAL MEDICAL CENTER, SAVANNAH 31404
WHYTE, DANA F. 29 ACT AN
1000 JOHNSON FERRY RD, ATLANTA 30342
WHYTE, HENRY J. 17 ACT D
1230 JOHNSON FERRY RD, MARIETTA 30067
WIEGAND, STEWART E. 29 ACT D
6500 VERNON WOODS DR, ATLANTA 30328
WIELAND, WILLIAM F. 17 ACT P
1999 CLIFF VALLEY WAY, ATLANTA 30329
WIER, MARION A. 54 ACT R
PO BOX 10106, AUGUSTA 30903
WIGGINS, ROY A., JR. 29 ACT IM
105 COLLIER RD NW, ATLANTA 30309
WIGH, RUSSELL E. 54 R R
3601 BURNING TREE CT, AUGUSTA 30907
WIGHT, ROBERT P. 66 ACT IM
BOX 947, TIFTON 31793
WILBER, JOSEPH A. 29 ACT IM
300 INTERSTATE N, ATLANTA 30339
WILCOX, C.R. 27 ACT OBG
10 HOSPITAL CIR, ROME 30161
WILCOX, ROBERT B. 29 ACT U
25 PRESCOTT ST NE STE 6434, ATLANTA 30308
WILDEY, ROY A. 11 ACT R
9 MEDICAL ARTS CENTER, SAVANNAH 31405
WILOSTEIN, ALBERT 29 ACT GS
849 PEACHTREE ST NE, ATLANTA 30308
WILDSTEIN, GILBERT 16 ACT TS
29 SW UPPER RIVERDALE RD, RIVERDALE 30274
WILDSTEIN, WALTER B. 29 ACT GS
849 PEACHTREE ST NE, ATLANTA 30308
WILHELM, CHARLES C. 17 ACT IM
833 CAMPBELL HILL ST ' 230, MARIETTA 30090
WILKERSON, LESLIE A. 68 ACT OBG
303 SMITH ST, LA GRANGE 30240
WILKES, JOSEPH S. 29 ACT ORS
35 COLLIER RD NW STE 520, ATLANTA 30367
WILKES, LESLIE L. 11 ACT ORS
44 MEDICAL ARTS, SAVANNAH 31405
WILKES, W.A. 54 ACT PD
1203 HIGHLAND AVE, AUGUSTA 30904
WILKIEMEYER, RALPH M. 29 ACT U
3280 HOWELL MILL RD NW, ATLANTA 30327
WILKINS, S.A., JR. 29 R ND

WILKS, STEPHEN M. 29 ACT DR
35 COLLIER RD NW STE 305, ATLANTA 30309
WILLERS, OONALD R. 34 ACT ORS
650 BROAD ST SE, GAINESVILLE 30505
WILLEY, LOY W. 29 ACT OPH
1275 CLEVELAND AVE, EAST POINT 30344
WILLIAMS, A.F. 11 ACT IM
622 EAST 52ND ST, SAVANNAH 31405
WILLIAMS, ANDRE O. 29 ACT OBG
3011 RAINBOW DR STE A, DECATUR 30034
WILLIAMS, BYRON 29 ACT CD
5665 PEACHTREE DUNWOODY RD, ATLANTA 30342
WILLIAMS, C.J. 11 ACT IM
PO BOX 22757, SAVANNAH 31403
WILLIAMS, CHARLES ROY 39 R FP
126 NORTH MAIN ST, WADLEY 30477
WILLIAMS, DAVID C., JR. 54 ACT U
1142 DRUID PARK, AUGUSTA 30904
WILLIAMS, GEORGE A. 29 ACT OBG
135 MONTGOMERY FERRY RD NE, ATLANTA 30309
WILLIAMS, GEORGE P. 54 ACT OBG
1505 WINTER ST, AUGUSTA 30904
WILLIAMS, H.J., JR. 06 ACT PD
1624 COLEMAN AVE, MACON 31201
WILLIAMS, JACK B. 54 ACT AN
MEDICAL COLLEGE OF GEORGIA, AUGUSTA 30901
WILLIAMS, JACK G. 18 ACT PD
PO BOX 568, DOUGLAS 31533
WILLIAMS, JOHN L. 54 ACT NS
820 ST SEBASTIAN WAY, AUGUSTA 30910
WILLIAMS, JOHN W., JR. 35 ACT FP
47 AUGUSTA RD, LAVONIA 30553
WILLIAMS, JOSEPH P., JR. 15 ACT NS
PO BOX 6147, ATHENS 30604
WILLIAMS, MALCOLM H. 17 ACT IM
3001 SOUTH COBB DR SE, SMYRNA 30080
WILLIAMS, OTIS J., JR. 50 ACT OBG
PO BOX 848, EASTMAN 31023
WILLIAMS, RALPH C. 29 R PH
2216 LESTER DR, ALBUQUERQUE NM 87112
WILLIAMS, ROBERT A. 29 ACT OM,FP
3900 MOTORS IND WAY, DORAVILLE 30360
WILLIAMS, ROBERT A. 22 ACT OM
1034 WINDING RIDGE CT, DUNWOODY 30338
WILLIAMS, ROYCE MAHONE 72 ACT OBG
3531 BOONE PARK AVE, JACKSONVILLE FL 32205
WILLIAMS, THEODORE G. 23 ACT ORS
1105 PALMYRA RD, ALBANY 31708
WILLIAMS, THOMAS H. 06 ACT GS
781 SPRING ST, MACON 31201
WILLIAMS, VIRGIL B. 59 ACT GS
505 BROOKWOOD TERR, GRIFFIN 30223
WILLIAMS, WILLIAM A., JR. 06 ACT FP
5297 BRANDYWINE DR, MACON 31204
WILLIAMS, WILLIAM TALBERT 17 ACT IM
696 CONCORD RD, SMYRNA 30080
WILLIAMS, WILLIS H. 29 ACT OS
1365 CLIFTON RD NE, ATLANTA 30322
WILLIAMSON, C. OAVIS 02 ACT OPH
540-A WEST THOMAS ST, MILLEDGEVILLE 31061
WILLINGHAM, ROBERT T., JR. 29 ACT ORS
35 COLLIER RD NW, ATLANTA 30309
WILLIS, TOM V., JR. 30 ACT GS
3215 SHRINE RD, BRUNSWICK 31520
WILLOUGHBY, DAN H. 11 ACT IM
2 MIDTOWN MEDICAL CENTER, SAVANNAH 31401
WILLS, BENJAMIN C. 11 ACT P
604 EAST 67TH ST, SAVANNAH 31405
WILLS, C.E., JR. 78 ACT FP
119 GORDON ST, WASHINGTON 30673
WILLS, S. ANGIER 22 ACT ON
755 COLUMBIA DR STE 613, DECATUR 30030
WILLS, WILLIAM R., JR. 18 ACT FP
PO BOX 32, DOUGLAS 31533
WILSON, C.A., JR. 30 ACT FP
PO BOX 1956, BRUNSWICK 31521
WILSON, COLON H., JR. 29 ACT IM
1365 CLIFTON RD NE, ATLANTA 30322
WILSON, FRANK A., III 61 ACT IM
PO BOX 247, LESLIE 31764
WILSON, FRANK L., JR. 29 ACT GS
35 COLLIER RD NW, ATLANTA 30309
WILSON, HENRY H. 22 ACT PD
1510 OAK GROVE RD STE 6, DECATUR 30033

WILSON, J.S. 29 ACT IM
490 PEACHTREE ST NE, ATLANTA 30308
WILSON, JOHN P. 29 ACT GS
315 BOULEVARD NE, ATLANTA 30312
WILSON, LOUIS A. 29 ACT OPH
1365 CLIFTON RD NE, ATLANTA 30322
WILSON, OHLEN R. 54 ACT FP
3589 OAKMONT CT, MARTINEZ 30907
WILSON, RICHARO H. 47 ACT PS
2200 NORTH AVE, COLUMBUS 31904
WILSON, ROY G. 11 ACT PS
5105 PAULSEN ST, SAVANNAH 31405
WINE, MERVIN B. 65 ACT A
602 EAST SEIXAS ST, THOMASVILLE 31792
WINIARSKI, NILOA 17 ACT PTH
PO BOX 6, AUSTELL 30001
WINNER, JONATHAN O. 29 ACT PD
6500 VERNON WOODS DR NE, ATLANTA 30328
WINOKUR, STANLEY H. 29 ACT ON
993-D JOHNSON FERRY RD NE, ATLANTA 30342
WINSTON, R.K. 56 ACT OPH
DOCTORS BLDG, VALDOSTA 31602
WIRTH, FREMONT P. 11 ACT NS
4 JACKSON BLVD, SAVANNAH 31405
WITHAM, A. CALHOUN 54 ACT IM
MEDICAL COLLEGE OF GEORGIA, AUGUSTA 30912
WITHERINGTON, ROY 54 ACT U
MEDICAL COLLEGE OF GEORGIA, AUGUSTA 30912
WITHINGTON, JOHN C. 11 ACT IM
1801 ABERCORN ST, SAVANNAH 31499
WITRAK, BONNIE J. 29 I&R R
80 BUTLER ST SE, ATLANTA 30303
WOFFORD, BENJAMIN H., JR. 17 ACT PS
684 CHEROKEE ST, MARIETTA 30060
WOFFORO, MICHAEL W. 29 ACT OS
315 BOULEVARD NE STE 100, ATLANTA 30312
WOJNOWICH, LEONARD S. 11 ACT FP
361 COMMERCIAL DR, SAVANNAH 31406
WOLFE, WILLIAM W., JR. 11 ACT P
515 EAST 63RD ST, SAVANNAH 31405
WOLFF, BERNARO P. 29 ACT IM
2643 DELLWOOD DR NW, ATLANTA 30305
WOLFF, JOHN MCD. 29 ACT IM
35 COLLIER RD NW, ATLANTA 30309
WOLFF, LUTHER H. 47 ACT GS
2120 PRESTON DR, COLUMBUS 31906
WOLFF, LUTHER H., JR.MD 47 ACT GS
MEDICAL ARTS BLDG STE 203, COLUMBUS 31901
WOLFF, WILLIAM A. 47 ACT GS
MEDICAL ARTS BLDG, COLUMBUS 31901
WOLFMAN, RICHARD M. 29 ACT R
993 JOHNSON FERRY RD NE, ATLANTA 30342
WOOD, CLAYTON E. 23 ACT D
426 SECOND AVE, ALBANY 31701
WOOO, HOMER P. 58 ACT FP
CLAY COUNTY HOSPITAL, FT GAINES 31751
WOOD, JAMES H. 29 ACT NS
1365 CLIFTON RD NE, ATLANTA 30322
WOOD, MARCELLA O. 29 R PD
3764 BRIARCLIFF RD NE, ATLANTA 30345
WOOO, MARK G. 65 ACT NEP
114 MIMOSA DR, THOMASVILLE 31792
WOOD, RICHARO ELGIN, JR. 47 ACT FP
2300 MANCHESTER EXPY, COLUMBUS 31904
WOOO, WARNER, JR. 29 ACT ORS
5669 PEACHTREE-DUNWOODY RD, ATLANTA 30342
WOOO, WILLIAM A., JR. 29 R IM
3764 BRIARCLIFF RD NE, ATLANTA 30345
WOODALL, JAMES A. 69 ACT FP
316 WEST GORDON ST, THOMASTON 30286
WOODALL, WILLIAM P. 69 R FP
316 WEST GORDON ST, THOMASTON 30286
WOODARD, JOHN R. 29 ACT U
1365 CLIFTON RD NE, ATLANTA 30322
WOODARD, OTIS J., JR. 23 ACT P
1304 WHISPERING PINES RD, ALBANY 31707
WOOOHALL, J.P. 06 R GS
3855 OVERLOOK AVE, MACON 31204
WOODHAMS, J. TREVOR 29 ACT OPH
3280 HOWELL MILL RD NW, ATLANTA 30327
WOOOS, E. ASHBY 21 ACT FP
PO BOX 37, BAINBRIDGE 31717
WOODS, JAMES O. 23 ACT OBG
320 SECOND AVE, ALBANY 31701
WOODS, JOHN TERRANCE 27 ACT R
1104 MARTHA BERRY BLVD, ROME 30161
WOOOSIOES, KENNETH T. 29 ACT OM
125 PERIMETER CENTER WEST, ATLANTA 30348
WOOOSON, G.C., JR. 29 ACT IM
6500 VERNON WOODS DR NE, ATLANTA 30328
WOODWARD, BOLAN P. 56 ACT OBG
2704 NORTH OAK ST, VALDOSTA 31602
WOOOWARD, R. CRAIG 29 ACT IM
35 COLLIER RD NW STE 500, ATLANTA 30309
WOOOY, EDGAR, JR. 29 ACT IM
35 COLLIER RD NW, ATLANTA 30309
WORO, J.J. 02 ACT P
1238 HIGHWAY 166 W, BOWDON 30108
WORMAN, ROBERT K. 47 ACT GS
PO BOX 951, COLUMBUS 31902
WORSLEY, NORMAN E., II 36 ACT AN
416 LAKE FRONT DR, WARNER ROBINS 31093
WORTH, JACK J., JR. 29 R GS
888 ARTWOOD RD NE, ATLANTA 30307
WRAY, BETTY B. 54 ACT PD
MEDICAL COLLEGE OF GEORGIA, AUGUSTA 30902
WRAY, CHARLES H. 54 ACT GS
MEDICAL COLLEGE OF GEORGIA, AUGUSTA 30902
WRIGHT, ASBURY D., JR. 34 ACT D
327 NORTHSIDE DR NW, GAINESVILLE 30501
WRIGHT, CHARLES K. 29 ACT OBG
35 COLLIER RD NW, ATLANTA 30309
WRIGHT, DONALD A. 11 ACT IM
2203 ABERCORN ST, SAVANNAH 31401
WRIGHT, GEORGE E. 29 ACT ORS
35 COLLIER RD NW STE 520, ATLANTA 30309
WRIGHT, GEORGE W. 54 ACT GS
2913 BRANSFORD RD, AUGUSTA 30904
WRIGHT, J. CARTER 10 R GS
105 BRANDYWINE TR, CARROLLTON 30117
WRIGHT, J. ROBERT 34 ACT OPH
295 WISTERIA DR, GAINESVILLE 30501
WRIGHT, JOHN D. 29 ACT OPH
25 PRESCOTT ST NE, ATLANTA 30308
WRIGHT, MALCOLM G. 30 I&R IM
520 OCEAN BLVD STE 115, ST SIMONS IS 31522
WRIGHT, STEPHEN C. 17 ACT CHP
2355 BOLTON RD NW, ATLANTA 30381
WRIGHT, THOMAS L. 17 ACT N
1680 MULKEY RD STE C, AUSTELL 30001
WU, CHEN N. 32 ACT GS
8954 HOSPITAL DR #105A, DOUGLASVILLE 30134
WU, CHUEN-SHIONG 70 ACT PD
790 BATTLEFIELD PKY, FT OGLETHORPE 30742
WYANT, JOHN R., JR. 17 ACT OBG
705 CAMPBELL HILL ST, MARIETTA 30060
WYATT, BARBARA 27 ACT IM
3 PROFESSIONAL CT, ROME 30161
WYATT, C.J., JR. 27 ACT IM
3 PROFESSIONAL CT, ROME 30161
WYATT, THOMAS E. 29 ACT PD
833 CAMPBELL HILL ST, MARIETTA 30060
WYLIE, JAMES E. 22 ACT OBG
1275-A MCCONNELL DR, DECATUR 30033
WYLIE, M.H. 54 ACT GS
837 CHAFFEE AVE, AUGUSTA 30904
WYLIE, WILLIAM J. 54 ACT IM
837 CHAFEE AVE, AUGUSTA 30904
WYNN, O.C. 72 ACT FP
861 FOLKS ST, WAYCROSS 31501
WYNN, ROBERT A. 11 ACT TS
5400 SUTLIVE ST STE 1, SAVANNAH 31405
WYNNE, MORGAN O., JR. 36 ACT PD
116 SOUTH HOUSTON RD, WARNER ROBINS 31093
WYNNE, ROBERT MILETUS 06 ACT FP
2305 INGLESIDE AVE, MACON 31204
WYSONG, EOWARO OALE 35 ACT FP
113 ATHENS ST, HARTWELL 30643

Y

YAGER, HOWARD S. 29 ACT FP
3109 EAST SHADOWLAWN AVE NE, ATLANTA 30305
YAGHMAI, FARIVAR 54 ACT PTH,NA
MEDICAL COLLEGE OF GEORGIA, AUGUSTA 30902
YALAMANCHILI, GANDHIJI 23 ACT IM,GE
1009 NORTH MONROE ST STE 107, ALBANY 31701
YANCEY, ASA G. 29 ACT GS
80 BUTLER ST SE, ATLANTA 30303
YANCEY, KIM B. 54 I&R D
10845 BUCKNELL DR, WHEATON MD 20902
YANG, LINOA LI-CHAO 11 ACT FP
3 MEDICAL ARTS CENTER, SAVANNAH 31405
YARBROUGH, JAMES E. 47 ACT OTO
1909 IRIS DR, COLUMBUS 31906
YARBROUGH, SIDNEY H., III 47 ACT ORS
2300 MANCHESTER EXPY, COLUMBUS 31904
YARN, CHARLES P., JR. 29 ACT PS
35 COLLIER RD NW, ATLANTA 30309
YATES, A.J., JR. 57 ACT FP
PO BOX 477, SOPERTON 30457
YAUGER, JOHN THOMAS 29 ACT IM
575 WEST PEACHTREE ST NW, ATLANTA 30308
YEAGER, EARL S. 11 ACT GS
5102 PAULSEN ST, SAVANNAH 31405
YECKLEY, JAMES A. 11 ACT D
835 EAST 65TH ST, SAVANNAH 31405
YEH, THOMAS J. 11 ACT TS
5112 PAULSEN ST STE 101, SAVANNAH 31405
YEOMANS, JAMES W. 75 ACT GS
PO BOX 67, JESUP 31545
YEOMANS, NEAL F. 72 R R
704 MAGNOLIA ST, WAYCROSS 31501
YOBS, ANNE ROOF 29 S PH
2687 OVERLOOK DR NE, ATLANTA 30345
YOCHEM, AUGUST S., JR. 29 ACT P
1970 CLIFF VALLEY WAY NE, ATLANTA 30329
YOE, LIONEL MEREDITH 47 ACT OPH
DOCTORS BLDG #109, COLUMBUS 31901
YOULES, OWEN K., JR. 56 ACT OBG
2704 NORTH OAK ST BLDG G, VALDOSTA 31602
YOUNG, MARION M. 70 R P,PM
LAFAYETTE MENTAL HEALTH, LAFAYETTE 30728
YOUNG, R.A. 27 ACT CD
203 PINE VALLEY RD, ROME 30161
YOUNG, ZELLNER C. 11 ACT GP
810 EAST 66TH ST, SAVANNAH 31405
YOUNGLESON, SHARON J. 29 ACT P
1970 CLIFF VALLEY WAY NE, ATLANTA 30329
YOUNT, AVIS B. 54 ACT D
820 ST SEBASTIAN WAY, AUGUSTA 30902
YOUNT, PETER S. 54 ACT D
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248 ARROWHEAD BLVD, JONESBORO 30236
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365 WINN WAY STE 100, DECATUR 30030
YU, FRANK 76 ACT AN
1700 ANTHONY AVE, DALTON 30720
YUN, IN W. 39 ACT FP
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ZAWORSKI, ROBERT E. 29 ACT PS
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ZEICHNER, WILLIAM D. 29 I&R GS
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ZIMMERMAN, MARK J. 29 ACT OBG
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ZIMMERMAN, ROBERT J. 06 R EM
4919-A RIVOLI DR, MACON 31204
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801 WEST EIGHTH ST, TIFTON 31794
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TLHASSE MEM REG MED CTR, TALLAHASSEE 32308
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KAY, FERDINAND V. 06 ACT FP
1221 NEWBERG AVE, MACON 31206
KEEHAN, JAMES E. 06 ACT OM
2800 WEAVER RD, MACON 31202
KELLEY, TERRY V. 06 I&R
MEDICAL CENTER OF CENTRAL GA, MACON 31208
KELLY, ELMO C., III 06 ACT D
380 HOSPITAL DR STE 300, MACON 31201
KELLY, FRANCIS B. 06 ACT ORS
770 PINE ST STE 400, MACON 31201
KELLY, GENE M. 06 ACT AN
148 TEN KNOLLS DR, MACON 31204
KESSINGER, JOHN M. 06 ACT CD,TS
770 PINE ST STE 300, MACON 31201
KING, J. LON, JR. 06 ACT OBG
380 HOSPITAL DR, MACON 31201
KIRSH, ALAN D. 06 ACT R
4707 OXFORD RD, MACON 31210
KULKARNI, VASUDEV V. 06 ACT EM
4927 RIVOLI DR, MACON 31210
LAMB, GAIL L. 06 ACT EM
4800 MUMFORD RD, MACON 31204
LANE, CARL E. 06 ACT TS
770 PINE ST STE 300, MACON 31201
LANFORD, CHARLES A. 06 ACT FP
7405 IND HWY, MACON 31206
LAWRENCE, JAMES O. 06 ACT GS
380 HOSPITAL DR, MACON 31201
LENNINGTON, B. RICHARD 06 ACT R
380 HOSPITAL DR STE 170, MACON 31201
LEONARD, MICHAEL M. 06 I&R FP
777 HEMLOCK ST, MACON 31201
LEWIS, WILLIAM EARL 06 ACT GS
380 HOSPITAL DR STE 430, MACON 31201
LIN, TA JUNG 06 ACT OBG
PO BOX 6000, MACON 31208
LINDSAY, JAMES B. 06 ACT GS
781 SPRING ST, MACON 31201
LIVINGSTON, JAMES A. 06 ACT FP
PO BOX 590, BYRON 31008
LOWE, THOMAS H. 06 ACT IM
618 ORANGE ST, MACON 31201
MADDOX, S.F. 06 ACT OPH
800 FIRST ST, MACON 31201
MAGNAN, C.G., JR. 06 ACT PS
380 HOSPITAL DR, MACON 31201
MANDEL, SAMUEL 06 ACT AN
PO BOX 6000, MACON 31208
MANN, DAVIO S. 06 ACT FP
645 FIRST ST, MACON 31201
MARTIN, J.O. 06 ACT OPH
745 PINE ST, MACON 31201
MAURIZI, CHARLES P. 06 ACT PTH
3049 MALVERN HILL DR, MACON 31201
MAY, CHARLES B. 06 ACT OBG
380 HOSPITAL DR, MACON 31201
MAY, WILLIAM E. 06 ACT IM
380 HOSPITAL DR STE 460, MACON 31201
MAYES, ALVA LOUIE, JR. 06 ACT PD
2009 VINEVILLE AVE, MACON 31204
MCALLISTER, ROBERT W. 06 ACT P
1627 TWIN PINE DR, MACON 31211
MCALLISTER, YVONNE P. 06 I&R FP
784 SPRING ST, MACON 31201
MCCARD, RAY H. 06 ACT P
596 ARLINGTON PL, MACON 31201
MCCUE, SEAN F. 06 ACT ORS
167 RIVERSIDE DR, MACON 31201
MCLENDON, JOE L. 06 ACT OPH
BACONSFIELD OFFICE PK, MACON 31211
MCMICHAEL, ROBERT S. 06 ACT GP
2869 NAPIER AVE, MACON 31204
MCMILLAN, E.C., JR. 06 ACT GS,FP
670 NEW ST, MACON 31201
MENENDEZ, JACK F. 06 ACT GS,ON
700 SPRING ST, MACON 31201
MEYER, THOMAS P. 06 ACT CD
752 HEMLOCK ST, MACON 31201
MILLER, WILLIAM C., JR. 06 I&R GS
MEDICAL CENTER OF CENTRAL GA, MACON 31210
MITCHELL, ALEX R. 06 ACT PTH
PO BOX 6000, MACON 31208
MITHANI, KAMRUDIN K. 06 I&R
784 SPRING ST, MACON 31201
MORGENSTERN, JACK A. 06 ACT P,CHP
3500 RIVERSIDE DR, MACON 31209
MORRIS, MICHAEL D. 06 ACT FP
1572 FOREST HILL RD, MACON 31210
MORTON, BENJAMIN D., III 06 ACT PTH
777 HEMLOCK ST, MACON 31201
NEAL, JULE C., JR. 06 ACT OBG
380 HOSPITAL DR, MACON 31201
NELSON, HOMER S. 06 ACT OPH
PO BOX 956, MACON 31202
NEUBERG, S. CHARLOTTE 06 ACT PD
2266 INGLESIDE AVE, MACON 31204
NEWTON, RALPH G., JR. 06 ACT U
718 FIRST ST, MACON 31201
NEWTON, W.R. 06 ACT PD
801 SPRING ST, MACON 31201
NOLLER, STEPHEN A. 06 ACT CD
770 PINE ST STE 480, MACON 31201
O'SHAUGHNESSEY, W. JOHN, JR. 06 ACT IM
618 ORANGE ST, MACON 31201
OGBURN, CHARLES L., JR. 06 ACT IM
618 ORANGE ST, MACON 31210
OKEHI, OBI C. 06 ACT OBG
770 PINE ST STE 310, MACON 31201
OLNICK, HERBERT M. 06 R R
1700 PRESIDENTIAL WAY, W PALM BEACH 33401
ORR, WILLIAM W. 06 ACT PD
2009 VINEVILLE AVE, MACON 31204
OTHMAN, MUFID A. 06 ACT IM,NEP
770 PINE ST STE 410, MACON 31201
PAGE, JOHN A. 06 ACT OPH
800 FIRST ST, MACON 31201
PATTON, MARY L. 06 ACT IM
800 FIRST ST STE 330, MACON 31201
PATTON, SAMUEL E. 06 ACT IM
2923 GENERAL LEE RD, MACON 31204
PECHAL, FRANK D. 06 ACT GP
PO BOX 204, IRWINTON 31042
PENNINGTON, CLAUOE L. 06 ACT OTO
800 FIRST ST, MACON 31201
PERKINS, OAVID 06 I&R FP
MEDICAL CENTER OF CENTRAL GA, MACON 31208
PESKOE, STANLEY T. 06 ACT NEP,IM
BACONSFIELD OFFICE PARK, MACON 31201
PHELPS, PAUL R., SR. 06 ACT GS
770 PINE ST STE 330, MACON 31201
PHILLIPS, A.M., JR. 06 ACT ORS
380 HOSPITAL DR, MACON 31201
PHILLIPS, JAMES E. 06 ACT PTH
4946 BRITTANY DR, MACON 31204
PLAXICO, OAVID T. 06 ACT A,PDA
2327 INGLESIDE AVE, MACON 31204
POPE, JAMES TERRELL 06 ACT OBG
380 HOSPITAL DR, MACON 31201
POUNO, WILLIAM E. 06 ACT FP
670 NEW ST, MACON 31201
POWELL, MATTHEW J.G. 06 ACT FP
558 TAYLOR CT, MACON 31204
PRIM, GARY J. 06 ACT AN
1860 FLINTWOOD DR, MACON 31201
RAMAIYA, NALINI K. 06 I&R FP
MEDICAL CENTER OF CENTRAL GA, MACON 31210
RANDO, STEPHEN 06 ACT R
770 PINE ST STE 250, MACON 31201
RANKIN, FREO M., JR. 06 ACT AN
MEDICAL CENTER OF CENTRAL GA, MACON 31204
RAO, PULIPAKA B. 06 ACT IM,CD
770 PINE ST STE 460, MACON 31201
RAYBOURNE, JACK E. 06 ACT AN
2934 VICTORIA CIR, MACON 31201
RHAME, DONALD W. 06 ACT GS
700 SPRING ST, MACON 31201
RICHAROSON, CHARLES H., III 06 ACT ORS
770 PINE ST STE 400, MACON 31201
RIDLEY, C.L., JR. 06 ACT GS
TWO BACONSFIELD OFFICE PARK, MACON 31211
ROBERTS, TERRELL S. 06 I&R FP
784 SPRING ST, MACON 31201
ROBINSON, DONALD R. 06 I&R OBG
PO BOX 1046, BOX ELDER SD 57719
ROBINSON, JOE S. 06 ACT GS
770 PINE ST STE 320, MACON 31201
ROBINSON, JOE S. 06 ACT NS
740 HEMLOCK ST, MACON 31201
RODDENBERRY, HARVEY B. 06 ACT OBG
380 HOSPITAL DR STE 100, MACON 31201
ROGERS, JAMES W. 06 R EM
3055 GENERAL LEE RD, MACON 31204
ROGERS, JOHN J. 06 ACT GS
770 PINE ST STE 220, MACON 31201
ROGERS, T.E., JR. 06 ACT OBG
380 HOSPITAL DR, MACON 31201
ROWLAND, JAMES M., III 06 ACT IM
770 PINE ST STE 410, MACON 31201
ROWLEY, CHARLES M. 06 ACT N
740 HEMLOCK ST, MACON 31201
ROZIER, D.H. 06 ACT AN
5151 ZEBULON RD, MACON 31204
RUMBLE, CHARLES T. 06 ACT PD
RUMBLE RD E RTE 3 BOX 43, FORSYTH 31029
SANOERS, BEVERLY B., JR. 06 ACT D
1157 FORSYTH ST, MACON 31201
SCHLOTTMAN, GEORGE C. 06 ACT U
718 FIRST ST, MACON 31201
SCHNELL, FREDERICK M. 06 ACT HEM,ON
729 PINE ST, MACON 31201

SCHUESSLER, CARL C. 06 ACT OBG
380 HOSPITAL DR, MACON 31201
SCHWARTZ, LARRY A. 06 ACT PD
376 ROGERS AVE, MACON 31204
SCHWARTZ, ROBERT I. 06 ACT PD
376 ROGERS AVE, MACON 31204
SEALY, HUGH K. 06 ACT IM
765 SPRING ST, MACON 31201
SEARS, ROBERT A. 06 R NS
510 HIGH POINT N, MACON 31210
SHAKER, ISSAM JOHN 06 ACT CDS
770 PINE ST STE 300, MACON 31201
SHIELDS, JOSEPH D., III 06 ACT IM
618 ORANGE ST, MACON 31201
SHIRLEY, WILLIAM C. 06 ACT OBG
380 HOSPITAL DR #100, MACON 31201
SIKES, JAMES C. 06 ACT P
803 SPRING ST, MACON 31201
SIKES, ZACHARIAH S., JR. 06 R P
259 IDLE WILD RD, MACON 31210
SILLER, EVERARD J. 06 ACT N
829 FIRST ST, MACON 31201
SLAPPEY, EDWIN D. 06 ACT OBG
770 PINE ST STE 360, MACON 31208
SMAHA, JERRY JOSEPH 06 ACT R
888 PINE ST, MACON 31201
SMISSON, HUGH F. 06 ACT NS
740 HEMLOCK ST, MACON 31201
SMITH, JAMES FERRIS, JR. 06 ACT IM
729 PINE ST, MACON 31201
SMITH, NORMAN JOE 06 ACT ORS
380 HOSPITAL DR STE 125, MACON 31201
SMITH, PATTON P. 06 ACT FP
235 MEDICAL CT, FORSYTH 31029
SOMERS, WILLIAM H. 06 R R
2881 INGLESIDE AVE, MACON 31204
SOUMA, JOHN A. 06 ACT OBG
PO BOX 6000, MACON 31208
SPIVEY, OSCAR S. 06 ACT PD
1550 COLLEGE ST, MACON 31201
SREERAM, K.M. 06 ACT TS
700 SPRING ST, MACON 31201
STAHL, LOREN C. 06 ACT IM
618 ORANGE ST, MACON 31201
STAMPS, EDWARD ROE 06 R U
643 ORANGE ST, MACON 31201
STANLEY, CASSIUS M., III 06 ACT U
673 PINE ST, MACON 31201
STEFANIS, GEORGE S. 06 ACT NS
3 BACONSFIELD PK STE 80, MACON 31211
STEFANSSON, STURLA 06 ACT AN
777 HEMLOCK ST, MACON 31201
STELLING, HENRY G. 06 I&R OBG
118 DEERWOOD CIR, WARNER ROBINS 31093
STEPHENS, DAVID B. 06 ACT TS
770 PINE ST, MACON 31201
STEVENS, EDWARD L. 06 ACT OTO
800 FIRST ST, MACON 31201
STEWART, J. BENHAM 06 ACT GS
700 SPRING ST, MACON 31201
SUIT, JAMES I. 06 ACT OPH
626 FIRST ST, MACON 31098
SWARTOUT, JOSEPH R. 06 ACT OBG
1400 COLEMAN AVE, MACON 31207
TARABADKAR, SANJIWAN V. 06 ACT AN
PO BOX 6000, MACON 31210
TAUNTON, W. STEPHEN 06 ACT FP
100 CULLODEN RD, FORSYTH 31029
TERRY, THOMAS L. 06 ACT IM,CD
618-B ORANGE ST, MACON 31201
TERRY, WILLIAM H. 06 ACT IM
3 BACONSFIELD OFC PK STE 2, MACON 31201
THERIOT, GEORGIA M. 06 I&R FP
784 SPRING ST, MACON 31201
TIDWELL, REX W. 06 ACT R
380 HOSPITAL DR, MACON 31201
TIFT, HENRY H. 06 ACT IM
765 SPRING ST, MACON 31201
TREADWELL, TANDY W., JR. 06 ACT FP
784 SPRING ST, MACON 31201
TRIPP, JOHN N. 06 ACT FP
MERCER UNIV SCHOOL OF MED, MACON 31207
VAN DE WATER, JOSEPH M. 06 ACT CD,TS
777 HEMLOCK ST, MACON 31201
VERNON, MINOR C. 06 ACT PD
770 PINE ST STE 350, MACON 31201
WALKER, DUNCAN, JR. 06 ACT OTO
700 SPRING ST, MACON 31201
WALKER, GARY K. 06 ACT PTH
MEDICAL CENTER OF CENTRAL GA, MACON 31208
WALKER, ROBERT J., JR. 06 ACT PH
779 DOWNING ST, MACON 31204
WATSON, EDWIN R. 06 ACT PD
745 PINE ST, MACON 31201
WEAVER, ALEXANDER H.S. 06 ACT ORS
870 HIGH ST, MACON 31201
WEAVER, WILLIAM H.M. 06 ACT IM
700 SPRING ST, MACON 31201
WEKSLER, LUIZ 06 ACT AN
135 HINES TERR, MACON 31204
WELLBORN, ROGER G. 06 I&R FP
784 SPRING ST, MACON 31201
WELLS, CHARLES C., JR. 06 ACT N
829 FIRST ST, MACON 31201
WELLS, JAMES M. 06 ACT AN
2983 VICTORIA DR, MACON 31201
WELLS, JOHN A. 06 ACT GS
700 SPRING ST, MACON 31201
WELLS, PERRY B. 06 ACT OBG
770 PINE ST STE 360, MACON 31201
WILLIAMS, H.J., JR. 06 ACT PD
1624 COLEMAN AVE, MACON 31201
WILLIAMS, THOMAS H. 06 ACT GS
781 SPRING ST, MACON 31201
WILLIAMS, WILLIAM A., JR. 06 ACT FP
5297 BRANDYWINE DR, MACON 31204
WOODHALL, J.P. 06 R GS
3855 OVERLOOK AVE, MACON 31204
WYNNE, ROBERT MILETUS 06 ACT FP
2305 INGLESIDE AVE, MACON 31204
ZIMMERMAN, ROBERT J. 06 R EM
4919-A RIVOLI DR, MACON 31204

7—BLUE RIDGE

ATKINS, KENNEY S. 07 ACT GP
7 MAIN ST, MCCAYSVILLE 30555
BOND, ROBERT K. 07 ACT IM
PO BOX E, ELLIJAY 30540
BURNS, R.A. 07 ACT FP
BOX 725, BLUE RIDGE 30513
FERNANDEZ, E.J. 07 ACT FP
PO BOX 587, ELLIJAY 30540
PHURROUGH, STEVE E. 07 S FP
75 SOUTHSIDE CHURCH ST, ELLIJAY 30540
ROOF, JACK B., JR. 07 ACT FP
PO BOX 1108, BLUE RIDGE 30513

8—OGEECHEE RIVER

ABREU, VERGIL 08 ACT OBG
840 SYLVANIA RD, MILLEN 30442
ANDERS, MACELYN V. 08 R FP
203 WILDWOOD DR, STATESBORO 30458
ASERON, CIRILO, JR. 08 ACT R
307 NORTHSIDE DR E, STATESBORO 30458
BOHLER, C. EMORY 08 ACT FP
PO BOX 8, BROOKLET 30415
CAMPO, M. LEONARDO 08 ACT IM
130 NORTH GRAY ST, MILLEN 30442
CLEMONS, THURMAN 08 ACT GP
PO BOX 821, STATESBORO 30458
CONNELL, DON R. 08 ACT R
500 EAST GRADY ST, STATESBORO 30458
COPE, DOUGLAS O. 08 ACT OPH
PO BOX 1067, STATESBORO 30458
CURRY, LEON E. 08 ACT GP
PO BOX 538, METTER 30439
DANIEL, A.B. 08 ACT GS
PO BOX 592, STATESBORO 30458
DEAL, ALBERT M. 08 ACT GS
PO BOX 647, STATESBORO 30458
DEAL, HELEN R. 08 R PD
PO BOX 647, STATESBORO 30458
DEAL, WILLIAM R. 08 ACT GS
DONEHOO ST, STATESBORO 30458
FRESH, JAMES W. 08 ACT GP,PTH
PO BOX 10, SARDIS 30456
GLENN, FRANK D. 08 ACT U
412 NORTHSIDE DR E, STATESBORO 30458
GOODMAN, CAREY W., JR. 08 ACT FP
407 ZETTEROWER AVE, STATESBORO 30458
HAMES, CURTIS G. 08 ACT IM
2 NEWTON ST, CLAXTON 30417
JORDAN, STEPHEN M. 08 ACT IM
356 NORTHSIDE DR E, STATESBORO 30458
KENT, WILLIAM F. 08 ACT OBG
PO BOX 1066, STATESBORO 30458
LAUN, FREDERICK M. 08 ACT ORS
412 NORTHSIDE DR E, STATESBORO 30458
LOVELESS, GARY R. 08 ACT ORS
412 NORTHSIDE DR E, STATESBORO 30458
LOVETT, KATHRYN S. 08 ACT P
PO BOX 486, STATESBORO 30458
MACCAUGHELTY, T. CAMERON 08 ACT AN
PO BOX 567, STATESBORO 30458
MOONEY, ALFONSO J., III 08 ACT FP
PO BOX 508, STATESBORO 30458
MULKEY, A.P. 08 ACT GS
110 EAST COLLEGE AVE, MILLEN 30442
PENCE, ROBERT L. 08 ACT GP
PO BOX 538, METTER 30439
REDDY, SUDHAKARA M. 08 ACT PD
PO BOX 488, STATESBORO 30458
RICHARDSON, CHARLES R. 08 ACT OBG
PO BOX 1066, STATESBORO 30458
ROBINSON, ROBERT S. 08 ACT GP
PO BOX 538, METTER 30439
ROSHTO, JAMES A. 08 ACT OBG
PO BOX 1066, STATESBORO 30458
SANTIAGO, MARCELO R. 08 ACT GS
PO BOX 800, CLAXTON 30417
SCARBOROUGH, DAVID W. 08 ACT FP
412 NORTHSIDE DR, STATESBORO 30458
SMITH, H. RANDOLPH 08 ACT FP
412 NORTHSIDE DR E, STATESBORO 30458
SMITH, J. DORSEY 08 ACT FP
PO BOX 538, METTER 30439
STAIMAN, RICHARD I. 08 ACT PTH
PO BOX 1048, STATESBORO 30458
SWINT, ROBERT H. 08 ACT GS
PO BOX 1088, STATESBORO 30458
TILLMAN, SAMUEL P. 08 ACT IM
302 DONEHOO ST, STATESBORO 30458
TILSON, PAUL J. 08 ACT U
422 NORTHSIDE DR E, STATESBORO 30458
WHITE, STEPHEN R., MD FACS 08 ACT GS
412 NORTHSIDE DR, STATESBORO 30458
WHITLOCK, PAUL A., JR. MD FACS 08 ACT GS
412 NORTHSIDE DRIVE, STATESBORO 30458

9—BURKE

BYNE, J.M., JR. 09 ACT IM
205 SEVENTH ST, WAYNESBORO 30830

GREEN, CHARLES G. 09 ACT FP
222 SIXTH ST, WAYNESBORO 30830
GRIFFIN, SHELLEY A. 09 ACT PD
304 JONES AVE, WAYNESBORO 30830
JACKSON, JOSEPH L. 09 ACT FP
PO BOX 230, WAYNESBORO 30830
SANDERS, HARVEY J., JR. 09 ACT IM
304 JONES AVE, WAYNESBORO 30830
VOYLES, WALTER R. 09 ACT GS
307 FOURTH ST, WAYNESBORO 30830

10—CARROLL-HARALSON

ALLEN, R.O. 10 R GP
45 HEAD AVE, TALLAPOOSA 30176
ALLIGOOO, LAWRENCE 10 ACT PTH
TANNER MEMORIAL HOSPITAL, CARROLLTON 30117
ASTIN, PHIL C., JR. 10 ACT FP
702 DIXIE ST, CARROLLTON 30117
BATCHELOR, CURTIS A. 10 ACT FP
405 ALABAMA ST, BREMEN 30110
BERRY, ROBERT L. 10 R FP
611 NORTH AVE, VILLA RICA 30180
BOSS, J. LARRY 10 ACT FP
611 NORTH AVE, VILLA RICA 30180
BURSON, JOHN H., III 10 ACT OTO
802 DIXIE ST, CARROLLTON 30117
COLDITZ, RICHARO B. 10 ACT OBG
305 TANNER ST, CARROLLTON 30117
OENNEY, ROY L. 10 R OTO
130 WEST CLUB DR, CARROLLTON 30117
DOMM, ALBERT C. 10 ACT PTH
311 WEST EIGHTH ST, ROME 30161
DOWNEY, W.P. 10 ACT OM
49 HEAD AVE, TALLAPOOSA 30176
FLECK, RALPH E., JR. 10 ACT ORS
148 CLINIC AVENUE, CARROLLTON 30117
GENTRY, PAUL D. 10 ACT FP
524 DIXIE ST, CARROLLTON 30117
GODARD, JOHN E. 10 ACT OPH
160 CLINIC AVE, CARROLLTON 30117
GONZALEZ, EVANGELIO 10 ACT FP
611 NORTH AVE, VILLA RICA 30180
GRANT, EDWIN H. 10 ACT R
605 DIXIE ST, CARROLLTON 30117
HUBBARD, CHARLES N. 10 ACT ORS
148 CLINIC AVE, CARROLLTON 30117
JARRELL, ROBERT J. 10 ACT R
605 DIXIE ST, CARROLLTON 30117
JOHNSON, MARTIN L. 10 ACT GP
PO BOX 490, BOWDON 30108
LIPHAM, MARK L. 10 ACT IM
PO BOX 997, CARROLLTON 30117
MADDOX, HUGH G., JR. 10 ACT AN
PO BOX 1084, CARROLLTON 30117
MARTIN, FREDERICK W. 10 ACT OBG
AMBULANCE DR, CARROLLTON 30117
MARTIN, TALMADGE M. 10 ACT GS
619 DIXIE ST, CARROLLTON 30117
MCLENDON, HAROLO L. 10 ACT OBG
115 HOSPITAL DR, CARROLLTON 30117
MCLENOON, JULIAN K. 10 ACT US
405 ALABAMA AVE, BREMEN 30110
MILES, MARY RYAN 10 ACT US
202 CROFT ST, CARROLLTON 30117
MORROW, RICHARD C. 10 ACT U
GROOVER MEDICAL BLDG, CARROLLTON 30117
MUNOY, H. BRENT 10 ACT U
GROOVER MEDICAL BLDG, CARROLLTON 30117
PARRISH, JOE E. 10 ACT OBG
115 HOSPITAL DR, CARROLLTON 30117
PATRICK, E.V. 10 ACT IM
624 DIXIE ST, CARROLLTON 30117
POPE, JAMES CHANOLER 10 ACT CDS
619 DIXIE ST, CARROLLTON 30117
PRICE, LAWRENCE W. 10 ACT FP
611 NORTH AVE, VILLA RICA 30180
PRICE, VIRGINIA H. 10 ACT FP
611 NORTH AVE, VILLA RICA 30180
PRITCHETT, JOHN H., JR. 10 ACT US
405 ALABAMA AVE, BREMEN 30110
REEVE, THOMAS E., JR. 10 ACT GS
619 DIXIE ST, CARROLLTON 30117
ROBINSON, J.C. 10 ACT R
605 DIXIE ST, CARROLLTON 30117
ROSSOMONDO, ROGER M. 10 ACT OPH
101 CLINIC AVE, CARROLLTON 30117
SEAGO, RICHARD W. 10 ACT GS
405 ALABAMA AVE, BREMEN 30110
SMITH, W.P. 10 ACT GS
PO BOX 630, BOWDON 30108
STEVENSON, CHARLES E., JR. 10 ACT PD
523 DIXIE ST STE 7, CARROLLTON 30117
TALLEY, DEAN B. 10 ACT IM
523 DIXIE ST #5, CARROLLTON 30117
WARE, JOHN R. 10 ACT IM
523 DIXIE ST, CARROLLTON 30117
WATERS, BARBARA B. 10 ACT R
605 DIXIE ST, CARROLLTON 30117
WATTS, JUBAL R. 10 ACT ORS
148 CLINIC AVE, CARROLLTON 30117
WRIGHT, J. CARTER 10 R GS
105 BRANDYWINE TR, CARROLLTON 30117

11—GEORGIA MEDICAL SOCIETY

ACKERMAN, LARRY L. 11 ACT P
530 E 49TH ST, SAVANNAH 31405
ALEXANOER, J.L. 11 ACT TS,CDS
5400 SUTLIVE ST STE 1, SAVANNAH 31405
ALEXANDER, JAMES G. 11 ACT FP
508 EAST 61 ST, SAVANNAH 31405
ALVAREZ, M.L. 11 ACT PTH
12903 LARGO DR, SAVANNAH 31406
ANGELL, JOHN H. 11 ACT OBG
PO BOX 22729, SAVANNAH 31403
ARKIN, MURRAY C. 11 ACT IM
PO BOX 15238, SAVANNAH 31416
BAKER, ROY P. 11 ACT NS
4 JACKSON BLVD, SAVANNAH 31405
BALA, AYER 11 ACT IM,ON
PO BOX 22429, SAVANNAH 31403
BALL, WESLEY J. 11 ACT GS
1814 ABERCORN ST, SAVANNAH 31401
BARGERON, EUGENE P. 11 ACT ORS
PO BOX 22787, SAVANNAH 31405
BEDINGFIELD, HERBERT M. 11 ACT ORS
600-I EAST 67TH ST, SAVANNAH 31405
BEESON, CHARLES W., II 11 ACT CD
8 WHEELER ST, SAVANNAH 31405
BERENS, SANFORD V. 11 ACT R
5223 PAULSEN ST, SAVANNAH 31405
BERGERON, GLYNN A. 11 ACT DR
5223 PAULSEN ST, SAVANNAH 31405
BIGGERSTAFF, EDWARD O., III 11 ACT OBG
PO BOX 22788, SAVANNAH 31405
BISHOP, EMMETT R., JR. 11 ACT P
210 EAST HALL ST, SAVANNAH 31401
BLACKWELL, J. THOMAS, JR. 11 ACT AN
515 EAST 63 ST, SAVANNAH 31405
BODZINER, L.S. 11 ACT OBG
19 MEDICAL ARTS CENTER, SAVANNAH 31405
BOHANNON, DONALD S. 11 ACT AN
515 EAST 63RD ST STE 3, SAVANNAH 31405
BOLCH, SIDNEY J. 11 ACT CD
6 ST JOSEPH'S PROF PLAZA, SAVANNAH 31406
BOUSQUET, FRANKLYN P., JR. 11 ACT OPH
2 JACKSON BLVD, SAVANNAH 31405
BOWDEN, RALPH O. 11 ACT GP
22 EAST TAYLOR ST, SAVANNAH 31401
BOYD, CARL R. 11 ACT GS
#1 MEDICAL ARTS CENTER, SAVANNAH 31405
BRADBURY, ROBERT G. 11 ACT R
311 EAST HALL ST, SAVANNAH 31401
BRANDT, HENRY A. 11 ACT P
220 EAST HALL ST, SAVANNAH 31401
BRAWNER, D.L. 11 ACT OBG
PO BOX 22729, SAVANNAH 31403
BRENNAN, CARL H. 11 ACT PD
4 MEDICAL ARTS CENTER, SAVANNAH 31405
BRODERICK, JOHN R. 11 ACT IM
2203 ABERCORN ST, SAVANNAH 31401
BROWN, WILBERT O. 11 A
4 PIPEMAKER LN, SAVANNAH 31411
BUCKHAULTS, W.W. 11 ACT OPH
5354 REYNOLDS ST, SAVANNAH 31405
BUELVAS, RAUL S. 11 ACT ORS
7 ST JOSEPH PROFESS PLAZA, SAVANNAH 31406
BURGSTINER, CARSON B. 11 ACT OBG
5354 REYNOLDS ST STE 304, SAVANNAH 31405
CANNON, CLIFTON L., JR. 11 ACT NS
4 JACKSON BLVD, SAVANNAH 31405
CAPLAN, GERALD E. 11 ACT R
PO BOX 23089, SAVANNAH 31403
CARLTON, FRANK E. 11 ACT U
2515 HABERSHAM ST, SAVANNAH 31499
CARTER, MICHAEL P. 11 ACT R
5223 PAULSEN ST, SAVANNAH 31405
CARTER, ROBERT H. 11 ACT GS
4920 PAULSEN ST, SAVANNAH 31405
CENTER, A.H. 11 ACT P
10 MEDICAL ARTS CENTER, SAVANNAH 31405
CHENG, YUNG-SHENG 11 ACT OBG
5420 PAULSEN ST, SAVANNAH 31405
CLARKE, GEORGE D. 11 ACT AN
18 MAGNOLIA XING, SAVANNAH 31411
CLARY, W. UPTON 11 ACT NS
4 JACKSON BLVD, SAVANNAH 31405
CLARY, WILLIAM A. 11 ACT N
4 JACKSON BLVD, SAVANNAH 31499
CLAYTON, MAX L. 11 ACT AN
8 STEPHENSON AVE, SAVANNAH 31405
COBB, ELLIOTT A. 11 R ORS
20 EAST 52ND ST, SAVANNAH 31405
COLMERS, RUDOLF A. 11 ACT CD,IM
5354 REYNOLDS ST STE 222, SAVANNAH 31405
CONKLIN, HARVEY B. 11 ACT EM,GS
5278 HWY 80, GARDEN CITY 31408
COSTA, CONRAOO V., JR. 11 ACT FP
PO BOX 294, RINCON 31326
COSTRINI, ANTHONY M. 11 ACT IM,PUD
11706 MERCY BLVD, SAVANNAH 31408
COSTRINI, NICHOLAS V. 11 ACT IM,GE
911 EAST 67TH ST, SAVANNAH 31405
CUTTINO, JUDSON P. 11 ACT AN
8 STEPHENSON AVE, SAVANNAH 31406
DAILY, F. WILLSON 11 ACT AN
3 COUNTRY CLUB DR, SAVANNAH 31410
DANZIG, LAMONT EARL 11 ACT IM
PO BOX 15238, SAVANNAH 31416
OAROEN, WILLIAM ABNER, JR. 11 ACT GS
200 EAST 31ST ST, SAVANNAH 31499
OEGENHART, WILLIAM J. 11 ACT OPH
5354 REYNOLDS ST, SAVANNAH 31405
DEHAVEN, JOSEPH W. 11 ACT END,IM
40 MEDICAL ARTS CENTER, SAVANNAH 31405
DEKLE, JOHN L., JR. 11 ACT OBG
5212 PAULSEN ST, SAVANNAH 31405
DEL RIO, GABRIEL G. 11 ACT PD
3914 PONCE DE LEON, CORAL GABLES FL 33134
DELANCY, HERMAN 11 ACT GS
5102 PAULSEN ST, SAVANNAH 31405
OELOACH, ERVIN D. 11 ACT PS,MFS
515 EAST 63RD ST, SAVANNAH 31405
DERISO, H. CLARK 11 ACT ORS
44 MEDICAL ARTS CENTER, SAVANNAH 31405

DEWBERRY, JAMES W. 11 ACT ORS
7 ST JOSEPH'S PROF PLAZA, SAVANNAH 31406
DI BENEDETTO, ROBERT J. 11 ACT IM,PUD
PO BOX 15238, SAVANNAH 31416
DIMOND, KEITH A. 11 ACT NEP,IM
PO BOX 15238, SAVANNAH 31416
DOWNING, EDWARD F. 11 ACT NS
4 JACKSON BLVD, SAVANNAH 31405
DRAKE, CHARLES E. 11 ACT IM,CD
100 PARK AVE EAST, SAVANNAH 31401
DUNCAN, J. HARRY 11 ACT OPH
115 MCLAWS, SAVANNAH 31405
DUNN, LAURENCE B. 11 ACT GP
PO BOX 205, BLUFFTON SC 29910
DYNIN, MICHAELA 11 ACT P
6606 ABERCORN ST, SAVANNAH 31405
EDWARDS, A. JOSEPH, JR. 11 ACT OBG
PO BOX 23498, SAVANNAH 31499
EDWARDS, ERNEST G., JR. 11 ACT ORS
44 MEDICAL ARTS CENTER, SAVANNAH 31405
ELLIOTT, J.L. 11 ACT IM
212 EAST HUNTINGDON ST, SAVANNAH 31401
EVANS, JAMES P. 11 ACT PD
5102 PAULSEN ST #3, SAVANNAH 31405
FAGIN, RONALD R. 11 ACT IM
835 EAST 65TH ST, SAVANNAH 31405
FILLINGIM, DAVID B. 11 ACT FP
449 ABERCORN ST, SAVANNAH 31401
FILLINGIM, DAVID W. 11 ACT OBG
5354 REYNOLDS ST STE 422, SAVANNAH 31405
FILLINGIM, JOHN M. 11 ACT FP
449 ABERCORN ST, SAVANNAH 31401
FILSON, EDGAR J. 11 ACT R
9 MEDICAL ARTS CENTER, SAVANNAH 31405
FINGER, ELLIOTT R. 11 ACT PS
11706 MERCY BLVD, SAVANNAH 31406
FLANDERS, HUGH D. 11 ACT GS
22 MEDICAL ARTS CENTER, SAVANNAH 31405
FREEDMAN, L.M. 11 ACT GS
7704 HUNTERS GROVE, JACKSONVILLE FL 32216
FREEMAN, THOMAS R. 11 ACT GS
200 EAST 31ST ST, SAVANNAH 31401
GAINER, JAMES S., JR. 11 ACT CD
8 WHEELER ST, SAVANNAH 31405
GANNON, CARMEN 11 ACT IM
PO BOX 10086, SAVANNAH 31412
GERMAN, THOMAS L. 11 ACT ORS
5354 REYNOLDS STE 505, SAVANNAH 31405
GOLDBERG, RONALD F. 11 ACT ON,IM
5400 SUTLIVE ST STE 3, SAVANNAH 31405
GONGAWARE, ROBERT D. 11 ACT GS
200 EAST 31ST ST, SAVANNAH 31401
GONGAWARE, THEODORA L. 11 ACT IM
PO BOX 23089, SAVANNAH 31403
GOODWIN, BURTON D., JR. 11 ACT R
PO BOX 23089, SAVANNAH 31403
GOTTSCHALK, ROBERT B., SR. 11 R GS
BOX 40 BAYNARD PL RD, HILTON HEAD SC 29928
GUERRY, RODERICK L. 11 ACT PTH
PO BOX 9787, SAVANNAH 31402
HABERMAN, GEORGE G. 11 ACT GS
511 ARLINGTON RD, SAVANNAH 31406
HAHN, EDWARD E. 11 ACT PTH
11705 MERCY BLVD, SAVANNAH 31406
HAM, O. EMERSON, JR. 11 ACT N
4 JACKSON BLVD, SAVANNAH 31405
HARDEMAN, FRANK, JR. 11 ACT FP
3025 BULL ST, SAVANNAH 31405
HARRIS, JOHN A. 11 ACT IM
2203 ABERCORN ST, SAVANNAH 31401
HAYSMAN, MELVIN L. 11 ACT A,IG
5400 WATERS AVE, SAVANNAH 31404
HEFFERNAN, J. ANTHONY, JR. 11 ACT FP
20 MEDICAL ARTS CENTER, SAVANNAH 31405
HEIDARY, DARIUSH H. 11 ACT CDS,TS
5112 PAULSEN ST, SAVANNAH 31405
HEMPHILL, J. MICHAEL 11 ACT N
5105 PAULSEN ST STE 111, SAVANNAH 31405
HENDRIX, STEPHEN G. 11 ACT PUD
PO BOX 23677, SAVANNAH 31403
HETHERINGTON, THOMAS A. 11 ACT R
311 EAST HALL ST, SAVANNAH 31401
HISSAM, JAMES E. 11 ACT FP
361 COMMERCIAL DR, SAVANNAH 31406
HITCH, WILLIAM S. 11 ACT TS,CD
351 EAST COMMERCIAL DR, SAVANNAH 31406
HOFFMAN, FRANK 11 ACT OTO
24 MEDICAL ARTS CENTER, SAVANNAH 31405
HOLLAND, WALLACE E., JR. 11 I&R IM
MEMORIAL MEDICAL CENTER, SAVANNAH 31403
HOLLOMAN, J.J. 11 ACT GP
313 EAST HALL ST, SAVANNAH 31401
HOOD, E.D. 11 ACT FP
241 ABERCORN ST, SAVANNAH 31401
HOWARD, ALBERT R. 11 ACT AN
8 STEPHENSON AVE, SAVANNAH 31405
HOWARD, LEE, JR. 11 R PTH
12 EAST 50TH ST, SAVANNAH 31405
HOWARD, ROBERT M. 11 ACT PTH
622 EAST 44TH ST, SAVANNAH 31405
HUFFMAN, GALEN C. 11 ACT P
PO BOX 13607, SAVANNAH 31406
HUNT, JOHN H. 11 ACT PTH
PO BOX 23089, SAVANNAH 31403
HUTCHESON, MORRIS W. 11 ACT PD
5102 PAULSEN ST, SAVANNAH 31405
ISAACSON, RONALD 11 ACT GS
5102 PAULSEN ST STE 2, SAVANNAH 31405
JACKSON, JAMES W. 11 ACT GS
1 MEDICAL ARTS CENTER, SAVANNAH 31405
JENNINGS, JANE B. 11 ACT PTH,BLB
PO BOX 23103, SAVANNAH 31403
JOHNSON, G. HUGO, JR. 11 ACT GP
116 EAST OGLETHORPE AVE, SAVANNAH 31401
JORDAN, CARL R. 11 ACT GS
PO BOX 3567, SAVANNAH 31404
JUDY, JAMES C. 11 ACT U
PO BOX 14459, SAVANNAH 31406
JURGENSEN, PAUL F. 11 ACT IM
PO BOX 15238, SAVANNAH 31416
KANTER, W.W. 11 ACT GP
PO BOX 9621, SAVANNAH 31402
KELLY, JULIAN D., JR. 11 ACT ORS
601 EAST 66TH ST, SAVANNAH 31405
KELLY, WILLIAM D. 11 ACT PTH
11705 MERCY BLVD, SAVANNAH 31406
KENNERLY, R. MICHAEL 11 ACT CDS
5400 SUTLIVE ST STE 1, SAVANNAH 31405
KREH, GUSTAVE M. 11 ACT PD
4 MEDICAL ARTS CTR, SAVANNAH 31405
KURZBACH, ELMAR 11 DE4 GP
PO BOX 13144, SAVANNAH 31406
LANGE, STEPHEN J., JR. 11 ACT AN
8 STEPHENSON AVE, SAVANNAH 31405
LANGE, STEPHEN J., SR. 11 ACT GP
509 LEE BLVD, SAVANNAH 31405
LANIER, LONNIE R., JR. 11 ACT OBG
2 MEDICAL ARTS CENTER, SAVANNAH 31405
LAYGO, ROMUALDO M. 11 ACT GS
PO BOX 348, SPRINGFIELD 31329
LEBOS, HARVEY C. 11 ACT IM,HEM
PO BOX 23829, SAVANNAH 31403
LEE, J. MOULTRIE 11 ACT GS
200 EAST 31ST ST, SAVANNAH 31401
LEE, LAWRENCE, JR. 11 ACT IM
2203 ABERCORN ST, SAVANNAH 31401
LIPPITT, WILLIAM H. 11 R GS
106 MCLAWS ST, SAVANNAH 31405
LOGAN, J. ROBERT 11 ACT OTO
2203 ABERCORN ST, SAVANNAH 31401
LONG, ROBERT F. 11 ACT R
PO BOX 23089, SAVANNAH 31403
LONG, W.V. 11 ACT GS
540 EAST 49TH ST, SAVANNAH 31405
LYNCH, LAWRENCE J., JR. 11 ACT GS
5400 SUTLIVE ST STE 2, SAVANNAH 31405
MANER, F. DEBELE 11 ACT IM
2203 ABERCORN ST, SAVANNAH 31401
MARSICANO, ANTHONY R. 11 ACT FP
602 EAST 67TH ST, SAVANNAH 31405
MASROOR, MOHAMMAD A. 11 ACT IM,CD
5354 REYNOLDS ST STE 212, SAVANNAH 31405
MAZO, MILTON 11 ACT PD
4 MEDICAL ARTS CENTER, SAVANNAH 31499
MCALPINE, W. ESTHER 11 ACT PD
5354 REYNOLDS ST, SAVANNAH 31405
MCGEE, HARRY H., JR. 11 ACT R
311 EAST HALL ST, SAVANNAH 31401
MCGINNIS, JOHN C. 11 A PM
9830 SOUTH OSWEGO, TULSA OK 74136
MCGOLDRICK, THOMAS A., JR. 11 ACT IM
15 EAST GORDON ST, SAVANNAH 31401
MCGUGAN, A. DAVID 11 ACT D
46 MEDICAL ARTS, SAVANNAH 31405
MCNAUGHTON, PHILIP Z. 11 ACT D
7805 WATERS AVE #9-A, SAVANNAH 31406
MCREYNOLDS, B.A. 11 ACT GS
PO BOX 23089, SAVANNAH 31403
MEADOWS, JAMES A., III 11 ACT IM
11706 MERCY BLVD #6, SAVANNAH 31406
MEDART, WILLIAM S., JR. 11 ACT FP
6409 ABERCORN ST, SAVANNAH 31405
METTS, JAMES C., JR. 11 ACT IM
110 WEST GASTON ST, SAVANNAH 31401
MICHIGAN, STEPHEN 11 ACT U
2515 HABERSHAM ST, SAVANNAH 31401
MIKELL, JULIA L. 11 ACT N
207 EAST HALL ST, SAVANNAH 31401
MILLER, JAMES A. 11 ACT PTH
PO BOX 9787, SAVANNAH 31402
MILLER, JAMES W. 11 ACT CD
8 WHEELER ST, SAVANNAH 31405
MILLER, WILLIAM A. 11 ACT R
PO BOX 23089, SAVANNAH 31403
MORGAN, HARVEY V. 11 ACT GP
1805 ABERCORN ST, SAVANNAH 31401
MORRISON, JOSEPH V., JR. 11 ACT PD
4 MEDICAL ARTS CENTER, SAVANNAH 31405
MULHERIN, JOSEPH A. 11 ACT AN
711 EAST 44TH ST, SAVANNAH 31405
MURPHY, HARVEY J. 11 ACT GS
5354 REYNOLDS ST STE 420, SAVANNAH 31405
NASH, D.A. 11 ACT OM
5720 COLONIAL DR, SAVANNAH 31406
NASH, MICHAEL LAWRENCE 11 ACT NEP,IM
PO BOX 15238, SAVANNAH 31416
NETTLES, JOE L. 11 ACT ORS
PO BOX 22787, SAVANNAH 31405
NEVILLE, R.L., SR. 11 ACT GS
2115 BULL ST, SAVANNAH 31401
NICHOLS, FENWICK T., JR. 11 ACT IM
PO BOX 22757, SAVANNAH 31403
NORTHUP, JOHN D. 11 ACT IM,GE
12345 MERCY BLVD, SAVANNAH 31406
OLIVER, ROBERT L. 11 ACT GS
RT 3 BOX 306-C, SAVANNAH 31406
OLSON, CLYDE L. 11 ACT OPH
2 JACKSON BLVD, SAVANNAH 31405
OSBORNE, W.W. 11 R OBG
PO BOX 14686, SAVANNAH 31406
OSMAN, MAGDY A. 11 ACT FP
5354 REYNOLDS ST, SAVANNAH 31405
OSTEEN, CLARK L. 11 ACT AN
206 WEST BAY ST, SAVANNAH 31401
PACIFICI, JOSEPH 11 ACT GP
40 EAST 50TH ST, SAVANNAH 31405
PETKOVICH, MILA 11 ACT PTH
13104 STILLWOOD RD, SAVANNAH 31406

PHILBRICK, THOMAS H. 11 ACT R
311 EAST HALL ST, SAVANNAH 31401
PHILLIPS, ANDRO P. 11 ACT GP
323 EAST JONES ST, SAVANNAH 31401
PIATT, EDWARD D. 11 ACT R
9 MEDICAL ARTS CENTER, SAVANNAH 31405
PIKE, BENJAMIN L. 11 ACT IM
32 MEDICAL ARTS CENTER, SAVANNAH 31405
PORTER, JOHN E. 11 ACT GP
6605 ABERCORN ST, SAVANNAH 31405
POWERS, LEANDER K. 11 ACT GP
29 EAST JONES ST, SAVANNAH 31401
PRITZKER, MARTIN S. 11 ACT D
712 EAST 70TH ST, SAVANNAH 31405
PURCELL, DENT W. 11 ACT TR
PO BOX 7706, GARDEN CITY 31418
QUATTLEBAUM, J.K., JR. 11 ACT GS
3710 WATERS AVE, SAVANNAH 31404
QUATTLEBAUM, J.K., SR. 11 ACT GS
3710 WATERS AVE, SAVANNAH 31404
QUATTLEBAUM, ROBERT B., JR 11 ACT U
5354 REYNOLDS ST STE 416, SAVANNAH 31405
RABHAN, LEONARO J. 11 ACT GS
147 KEY HAVEN RD, KEY WEST FL 33040
RABUN, J.B. 11 ACT R
311 EAST HALL ST, SAVANNAH 31401
RAMSEY, SPEIR N. 11 ACT OBG
5354 REYNOLDS ST STE 318, SAVANNAH 31405
RATHBUN, LAWRENCE A., JR. 11 ACT AN
515 EAST 63RD ST STE 3, SAVANNAH 31405
REEVES, J. LANE 11 ACT OPH
2 JACKSON BLVD, SAVANNAH 31405
RHANGOS, WILLIAM C. 11 ACT ORS
5354 REYNOLDS STE 505, SAVANNAH 31405
ROBERTSON, MASON G. 11 R IM
1221 LAWNDALE RD, SAVANNAH 31406
ROLLINGS, HARRY E. 11 ACT IM
100 EAST PARK AVE, SAVANNAH 31401
ROSE, OANIEL W. 11 ACT OTO,AL
17 MEDICAL ARTS CENTER, SAVANNAH 31405
ROSEN, SAMUEL F. 11 ACT D
PO BOX 960, SAVANNAH BEACH 31328
ROSENGART, CARL L. 11 ACT N
23 WEST GORDON ST, SAVANNAH 31401
ROSSITER, FRANCIS P., JR. 11 ACT PDA,AL
5 MIDTOWN MEDICAL CENTER, SAVANNAH 31401
ROUTON, JAMES L. 11 ACT AN
5354 REYNOLDS ST STE 518, SAVANNAH 31405
RUF, LAWRENCE E. 11 ACT PS,MFS
515 EAST 63RD ST, SAVANNAH 31405
RUSSELL, ALEX P. 11 ACT PTH
PO BOX 23103, SAVANNAH 31403
SAFER, IRWIN H. 11 ACT P
515 EAST 63RD ST, SAVANNAH 31405
SANOERS, HERBERT F. 11 ACT N
4 JACKSON BLVD, SAVANNAH 31405
SAX, CHARLES E. 11 ACT OBG
1216 SWEETBRIAR CIR, SAVANNAH 31406
SCARBROUGH, ROGER W., JR. 11 ACT OBG
5354 REYNOLDS ST STE 424, SAVANNAH 31405
SCARDINO, PETER L. 11 ACT U
2515 HABERSHAM ST, SAVANNAH 31499
SCHLEY, RICHARD L., JR. 11 ACT PD
5509 PAULSEN ST, SAVANNAH 31405
SCHNEIDER, M.M. 11 ACT OBG
19 MEDICAL ARTS CENTER, SAVANNAH 31405
SCHNUCK, LLOYD B., JR. 11 ACT R
9 MEDICAL ARTS CENTER, SAVANNAH 31405
SCHULZE, RICHARD R. 11 ACT OPH
728 EAST 67TH ST, SAVANNAH 31405
SCOTT, JAMES I. 11 ACT GS
9-A MEDICAL ARTS CENTER, SAVANNAH 31405
SHEILS, ANDREW T., JR. 11 ACT ORS
7 ST JOSEPHS PROF PLAZA, SAVANNAH 31406
SHEPHERO, EDWIN C. 11 ACT PD
4 MEDICAL ARTS CENTER, SAVANNAH 31405
SHERMAN, ELOISE B. 11 ACT PTH
1710 EAST HENRY ST, SAVANNAH 31404
SIMS, JAMES A. 11 ACT AN
RTE 5 BOX 125 JS, COVINGTON LA 70433
SISSON, WILLIAM H. 11 ACT P
PO BOX 23089, SAVANNAH 31403
SMITH, DAVID H. 11 ACT PS
11706 MERCY BLVD #8, SAVANNAH 31406
SMITH, JAMES D. 11 ACT OBG
2 MEDICAL ARTS CENTER, SAVANNAH 31405
SPERIOSU, SIMON V. 11 ACT P
1202 BRIGHTWOOD DR, SAVANNAH 31406
STANLEY, THOMAS M. 11 ACT N
5105 PAULSEN ST STE 111, SAVANNAH 31405
STARR, DONALD C. 11 ACT R
311 EAST HALL ST, SAVANNAH 31401
STONE, R.L. 11 R AN
5737 COLONIAL DR, SAVANNAH 31406
STRINGER, EDWARD F. 11 ACT GS
#1 MEDICAL ARTS CENTER, SAVANNAH 31405
STUBBS, JOSEPH T., JR. 11 ACT OPH
PO BOX 14608, SAVANNAH 31406
SU, SHAW C.T. 11 ACT U
PO BOX 14459, SAVANNAH 31406
SUMMERS, ROLAND S. 11 ACT IM,PUD
PO BOX 23677, SAVANNAH 31403
SUTLIVE, WILLIAM G. 11 ACT OBG
5420 PAULSEN ST, SAVANNAH 31405
TAN, CARLOS Y. 11 ACT GS,GP
4 POOLER PROF PL, POOLER 31322
TAN, JOSEFINA C. 11 ACT GP,AN
PO BOX 38, GUYTON 31312
TANNER, DAVID E. 11 ACT R
PO BOX 23089, SAVANNAH 31403
THOMAS, DAVID M. 11 ACT OBG
36 MEDICAL ARTS CENTER, SAVANNAH 31405
THORNE, DARLENE C. 11 ACT PTH
11705 MERCY BLVD, SAVANNAH 31406
THORNTON, NANCY 11 ACT PD
108-A BUTLER AVE, TYBEE ISLAND 31328
TILLINGER, ARNOLD J. 11 ACT P
515 EAST 63RD ST, SAVANNAH 31405
TIMMS, DICKY W. 11 ACT GS
9-A MEDICAL ARTS CENTER, SAVANNAH 31405
TORAYA, JULES 11 ACT OBG
2512 HABERSHAM ST, SAVANNAH 31401
TORRES, SAMUEL A. 11 ACT U
PO BOX 14459, SAVANNAH 31406
TRAIN, JOHN KIRK, JR. 11 ACT OTO
23 EAST 65TH ST, SAVANNAH 31405
USHER, CHARLES, JR. 11 ACT NS
5354 REYNOLDS ST #519, SAVANNAH 31405
VALBUENA, D.A. 11 ACT AN
9 TOMACHICHI LN, SAVANNAH 31411
VICTOR, IRVING 11 ACT U
PO BOX 14459, SAVANNAH 31406
VICTOR, JULES, III 11 ACT IM,ON
PO BOX 14359, SAVANNAH 31406
VICTOR, JULES, JR. 11 ACT IM
PO BOX 14359, SAVANNAH 31406
WADE, JOHN S. 11 ACT GS
22 MEDICAL ARTS CENTER, SAVANNAH 31405
WALLACE, STUART M. 11 ACT PTH
PO BOX 22007, SAVANNAH 31403
WEBB, RAY D. 11 ACT GP
PO BOX 217, SPRINGFIELD 31329
WESSINGER, WILLIAM N. 11 ACT ORS,HS
800 EAST 70TH ST, SAVANNAH 31405
WEST, JOHN H. 11 ACT HEM,ON
PO BOX 23829, SAVANNAH 31403
WHELAN, EDWARD J. 11 ACT U
720 EAST 66TH ST, SAVANNAH 31405
WHIDDON, C. MAURICE 11 ACT GS
22 MEDICAL ARTS CENTER, SAVANNAH 31405
WHITWORTH, STEVEN R. 11 I&R GS
MEMORIAL MEDICAL CENTER, SAVANNAH 31404
WILDEY, ROY A. 11 ACT R
9 MEDICAL ARTS CENTER, SAVANNAH 31405
WILKES, LESLIE L. 11 ACT ORS
44 MEDICAL ARTS, SAVANNAH 31405
WILLIAMS, A.F. 11 ACT IM
622 EAST 52ND ST, SAVANNAH 31405
WILLIAMS, C.J. 11 ACT IM
PO BOX 22757, SAVANNAH 31403
WILLOUGHBY, DAN H. 11 ACT IM
2 MIDTOWN MEDICAL CENTER, SAVANNAH 31401
WILLS, BENJAMIN C. 11 ACT P
604 EAST 67TH ST, SAVANNAH 31405
WILSON, ROY G. 11 ACT PS
5105 PAULSEN ST, SAVANNAH 31405
WIRTH, FREMONT P. 11 ACT NS
4 JACKSON BLVD, SAVANNAH 31405
WITHINGTON, JOHN C. 11 ACT IM
1801 ABERCORN ST, SAVANNAH 31499
WOJNOWICH, LEONARO S. 11 ACT FP
361 COMMERCIAL DR, SAVANNAH 31406
WOLFE, WILLIAM W., JR. 11 ACT P
515 EAST 63RD ST, SAVANNAH 31405
WRIGHT, DONALD A. 11 ACT IM
2203 ABERCORN ST, SAVANNAH 31401
WYNN, ROBERT A. 11 ACT TS
5400 SUTLIVE ST STE 1, SAVANNAH 31405
YANG, LINDA LI-CHAO 11 ACT FP
3 MEDICAL ARTS CENTER, SAVANNAH 31405
YEAGER, EARL S. 11 ACT GS
5102 PAULSEN ST, SAVANNAH 31405
YECKLEY, JAMES A. 11 ACT D
835 EAST 65TH ST, SAVANNAH 31405
YEH, THOMAS J. 11 ACT TS
5112 PAULSEN ST STE 101, SAVANNAH 31405
YOUNG, ZELLNER C. 11 ACT GP
810 EAST 66TH ST, SAVANNAH 31405
ZERDEN, SOLOMON G. 11 ACT R
2 MULBERRY BLUFF DR, SAVANNAH 31406
ZIRKLE, JOHN G. 11 ACT GS
1217 BRIGHTWOOD DR, SAVANNAH 31406
ZOLLER, MICHAEL 11 ACT OTO
8 MEDICAL ARTS CENTER, SAVANNAH 31405

12—ELBERT

ARNOLD, MCALPIN H. 12 ACT FP
46 LAUREL DR, ELBERTON 30635
BURRELL, ZEB, JR. 12 ACT IM
46 LAUREL DR, ELBERTON 30635
CAMPBELL, HAROLD EUGENE 12 R FP
46 LAUREL AVE, ELBERTON 30635
HANKS, JACK B. 12 ACT FP
33 CHESTNUT ST, ELBERTON 30635
MICKEL, CAREY ALSTON, JR. 12 ACT GS
522 RHODES DR, ELBERTON 30635
O'NEAL, JOHN B., III 12 ACT GS
33 CHESTNUT ST, ELBERTON 30635
O'NEAL, PHYLLIS J. 12 ACT GER
33 CHESTNUT ST, ELBERTON 30635
POON, GLEN S.H. 12 ACT FP
33 CHESTNUT ST, ELBERTON 30635

13—GWINNETT-FORSYTH

ALEXANDER, W. SCOTT 13 ACT EM
FORSYTH CO HOSP ER, CUMMING 30130
ALVIG, OLAV H. 13 ACT DR
BOX 768, CUMMING 30130
BAGHERI, M.T. 13 ACT TS
719 SCENIC HWY SW, LAWRENCEVILLE 30245
BOLING, JAMES F. 13 ACT IM
FORSYTH COUNTY PARK RD, CUMMING 30130
BOTTOMS, WILLIAM R. 13 ACT FP
RTE 1 BOX 334, CUMMING 30130

BRAMBLETT, RUPERT H. 13 ACT FP
326 DAHLONEGA RD, CUMMING 30130
BRUECKNER, LAWRENCE T. 13 ACT ORS
2121 FOUNTAIN DR STE 500, SNELLVILLE 30278
CARLIN, RICHARD 13 ACT OPH
2347 LENORA CHURCH RD, SNELLVILLE 30278
CHELTON, LOUIS G., III 13 ACT EM
PO BOX 98, LAWRENCEVILLE 30247
CHERNECKY, RICHARD E. 13 ACT IM
719 SCENIC HWY STE D, LAWRENCEVILLE 30245
CONNER, WILLIAM C. 13 ACT P
PO BOX 427, SNELLVILLE 30278
DAMPOG, ALFONSO T. 13 ACT AN
6179 WINDSONG WAY, STONE MOUNTAIN 30087
DEGANIAN, JAVAD 13 ACT PD
2121 FOUNTAIN DR STE 200, SNELLVILLE 30278
DELGADO, MERCEDES L. 13 ACT GP
4653 FITZPATRICK WAY, NORCROSS 30092
DOVE, DONALD V. 13 R FP
PO BOX 310, GRAYSON 30221
DUNAGAN, H. JOSEPHINE ROSE 13 ACT PD
2121 FOUNTAIN DR STE 200, SNELLVILLE 30278
DUNN, WILLIAM R. 13 ACT PD
PO BOX 669, CUMMING 30130
EDEN, SAMUEL W. 13 ACT IM
1029 WINDING RIDGE CT, DUNWOODY 30338
EDWARDS, PHILLIP D. 13 ACT U
2121 FOUNTAIN DR STE D, SNELLVILLE 30278
EZZARD, GEORGE P. 13 ACT FP
105 CROGAN ST, LAWRENCEVILLE 30245
FLOYD, JOSEPH B. 13 ACT AN
2121-B FOUNTAIN DR, SNELLVILLE 30278
FREID, NORMAN D. 13 ACT OBG
2200 FOUNTAIN DR, SNELLVILLE 30278
HARRIS, STERLING A. 13 ACT R
BOX 460, BUFORD 30518
HONARVAR, SAMAD 13 ACT OTO
354 ARCADO RD, LILBURN 30247
HUNT, JAMES 13 ACT FP
PO BOX 398, DULUTH 30136
HYDRICK, JOHN T. 13 ACT OBG
3400 MCCLURE BRIDGE RD, DULUTH 30136
ISLEY, ROBERT A. 13 ACT PD
2121 FOUNTAIN DR, SNELLVILLE 30278
KENNEDY, T. EUGENE 13 ACT FP
5424 LITTLE MILL RD, BUFORD 30518
KESSLER, MICHAEL B. 13 ACT EM
970 CLEMENSTONE DR, ATLANTA 30342
KLEIN, STEVEN H. 13 I&R PD
1061 HOMEWOOD CT, DECATUR 30033
LEE, EVERETT M. 13 ACT IM
PO BOX 653, CUMMING 30130
LIPSITT, MICHAEL A. 13 ACT IM
719 SCENIC HWY, LAWRENCEVILLE 30245
LOIS, THOMAS A. 13 ACT PS
2121 FOUNTAIN DR STE K, SNELLVILLE 30278
MAGAT, WILFRIDO M. 13 ACT AN
2121-B FOUNTAIN DR, SNELLVILLE 30278
MARINKOVIC, STEVEN 13 ACT P,N
100 EAST CLAYTON ST, LAWRENCEVILLE 30245
MARTIN, DAN ALLEN 13 ACT GS
PO BOX 347, LAWRENCEVILLE 30246
MARTIN, ELISABETH 13 R OBG
PO BOX 946, CUMMING 30130
MARTIN, WILLIAM B. 13 ACT GP,IM
488 GWINNETT DR SW, LAWRENCEVILLE 30245
MASHBURN, MARCUS, JR. 13 ACT OBG
PO BOX 669, CUMMING 30130
MASON, M.H. 13 ACT FP
PO BOX 248, DULUTH 30136
MASON, MILES H., III 13 ACT GS
PO BOX 869, DULUTH 30136
MAULDIN, JOHN W. 13 ACT FP
1081 29 HWY S, LAWRENCEVILLE 30245
MCCLURE, JOHN N., JR. 13 ACT GS
210 DAHLONEGA ST STE 104, CUMMING 30130
MCCOY, MICHAEL J. 13 ACT OBG
4765 HIGHWAY 778 STE A, LILBURN 30247
MERZ, CHRISTIAN L. 13 ACT OTO
PO BOX 907, LILBURN 30247
MILLER, CECIL L. 13 ACT FP
BUFORD MEDICAL CLINIC, BUFORD 30518
MIZE, C. SHANNON 13 ACT FP
208 HUDSON ST, CUMMING 30130
MURRAY, WALTER A., JR. 13 ACT PD
3162 PIEDMONT RD NE, ATLANTA 30305
PETRY, GARY LYNN 13 ACT OM
367 BROOKSHIRE DR, LILBURN 30247
PICKFORD, LARRY BRUCE 13 ACT OTO
3400 MCCLURE BR RD, DULUTH 30136
PICKFORD, MICHAEL J. 13 I&R
3924 PLEASANT SHADE DR, DORAVILLE 30340
QUINN, CORINNE F. 13 ACT IM
LANGLEY DR, LAWRENCEVILLE 30245
RATTAN, KAMAL K. 13 ACT ORS
2121 FOUNTAIN DR STE E, SNELLVILLE 30278
SIMS, FAYETTE A., JR. 13 R GP
488 GWINNETT DR, LAWRENCEVILLE 30245
SOLSONA, CARLOS R. 13 ACT GS
2151 FOUNTAIN DR ' 102-A, SNELLVILLE 30278
TOOTLE, GEORGE S. 13 ACT GS
PO BOX 35, DULUTH 30136
TOOTLE, JERRY C. 13 ACT GS
PO BOX 746, DULUTH 30136
UNTERMAN, MARC I. 13 ACT CD
719 SCENIC HWY, LAWRENCEVILLE 30245
WAGES, TOM L. 13 ACT FP
BUFORD MEDICAL CLINIC, BUFORD 30518

14—CHEROKEE-PICKENS

ANDERSON, ROBERT T. 14 ACT DR
5 ETOWAH TER, CANTON 30114
ANDREWS, CHARLES R., JR. 14 ACT GS
PO BOX 308, CANTON 30114
BOSWELL, T.C. 14 ACT FP
BOX 156, TATE 30177
CAUBLE, JOHN A. 14 ACT FP
PO BOX 1048, CANTON 30114
COLLINS, DAVID R. 14 ACT IM
110 WALESKA RD, CANTON 30114
CUTTS, WILLIAM G., JR. 14 ACT GS
651 SHOAL CREEK RD, CANTON 30114
DARNELL, D.T. 14 ACT FP
TATE 30177
DAVIS, HARRY N. 14 ACT FP
110 WALESKA RD, CANTON 30114
EVANS, CASSANDRA B. 14 ACT EM
2301 WALESKA RD, CANTON 30114
FLINT, L. AUSTIN 14 ACT R
110 WALESKA RD, CANTON 30114
GEESLIN, JAMES M. 14 ACT GS
110 WALESKA RD, CANTON 30114
GLAZEBROOK, GEORGE W. 14 ACT GS
110 WALESKA RD, CANTON 30114
GOLD, HOMER L., JR. 14 ACT FP
110 WALESKA RD, CANTON 30114
GONZALEZ, FRANCISCO E. 14 ACT OBG
PO BOX 311, CANTON 30114
GREGG, PATRICIA M. 14 ACT AN
307 HEMBREE HILL RD, CANTON 30114
HENDRIX, ARTHUR M. 14 R FP
465 WEST CLOVERHURST AVE, ATHENS 30606
LOOPER, BEN K. 14 ACT OBG
RTE 6 SUNSET DR, CANTON 30114
MARTINEZ, CARLOS B. 14 ACT FP
BOX 453 MAIN ST, BALL GROUND 30107
NICHOLS, W.H. 14 ACT FP
110 WALESKA RD, CANTON 30114
PERROW, G.H. 14 ACT FP
201 EAST SPRING ST, JASPER 30143
ROPER, E.A. 14 ACT FP
708 CHURCH ST, JASPER 30143
RUPPEL, JAMES W. 14 ACT FP
110 WALESKA RD, CANTON 30114
ST. AMANT, WILLIAM C. 14 ACT EM
RT JONES HOSPITAL, CANTON 30114
WARD, NORMAN S. 14 ACT FP
PO BOX 1038, CANTON 30114

15—CRAWFORD W. LONG

ABNEY, HOWARD T. 15 ACT GS
740 PRINCE AVE, ATHENS 30601
ALLEN, JOHN J. 15 ACT FP
160 TILLMAN LN, ATHENS 30606
BARRY, WILLIAM E. 15 ACT D
740 PRINCE AVE, ATHENS 30601
BEALL, JAMES H. 15 ACT P
700 OGLETHORPE AVE, ATHENS 30606
BERGER, ISRAEL REUBEN 15 R R
I 703 W CHARLESTON BLVD, LAS VEGAS NV 89102
BONNER, WILLIAM H. 15 ACT PD
740 PRINCE AVE, ATHENS 30601
BOWEN, WILLIAM L., JR. 15 ACT OBG
1010 PRINCE AVE, ATHENS 30601
BOYD, AUGUSTUS B. 15 ACT AN
PO BOX 1732, ATHENS 30601
BRANYON, DONALD L., JR. 15 ACT OBG
1010 PRINCE AVE, ATHENS 30601
BROWN, WALTER J., JR. 15 ACT IM
UNIVERSITY HEALTH SERVICE, ATHENS 30602
BURNETT, CLAUDE A., III 15 S OS
468 NORTH MILLEDGE AVE, ATHENS 30601
CABANISS, W. HARVEY, JR. 15 ACT D
1010 PRINCE AVE, ATHENS 30601
CASKIN, CLINTON R.J., JR. 15 ACT U
245 WESTVIEW DR, ATHENS 30601
CLARK, NILE R. 15 ACT FP
1160 PRINCE AVE, ATHENS 30601
CLAY, JAMES R. 15 ACT PTH
ATHENS GENERAL HOSPITAL, ATHENS 30613
COHEN, LARRY A. 15 ACT R
1 HUNTCLIFF WAY, ATHENS 30606
COOPER, CLAIRE V. 15 ACT P
PO BOX 8046, ATHENS 30603
COSTANTINO, MARK J. 15 ACT GS
1010 PRINCE AVE, ATHENS 30601
CREAGH, GERARD B. 15 ACT PH
555 MILLEDGE CIR, ATHENS 30601
CROSBY, WILLIAM V. 15 ACT OBG
740 PRINCE AVE, ATHENS 30601
CRYMES, JOHN M. 15 ACT AN
108 VALLEYWOOD DR, ATHENS 30606
CUFF, JOHN V. 15 ACT NS
1010 PRINCE AVE, ATHENS 30606
CURTIS, JOHN R. 15 ACT P
UNIVERSITY HEALTH SERVICES, ATHENS 30602
DAVIS, PAUL L., JR. 15 ACT DR
445 WEST CLOVERHURST AVE, ATHENS 30606
DEMPSEY, JAMES E. 15 ACT OTO
1010 PRINCE AVE, ATHENS 30601
DEUTSCH, ANTHONY J. 15 ACT IM
700 OGLETHORPE AVE, ATHENS 30606
DICKS, ROBERT E., III 15 ACT NS
1010 PRINCE AVE, ATHENS 30606
DUBOSE, BOLLING S., JR. 15 ACT IM
225 SOUTH MILLEDGE, ATHENS 30601
ELDER, JOHN F. 15 ACT OBG
740 PRINCE AVE, ATHENS 30601
ERWIN, GOODLOE Y. 15 ACT IM
1010 PRINCE AVE, ATHENS 30601
FORD, HENRY J. 15 ACT P
1010 PRINCE AVE, ATHENS 30601
FOREHAND, RONALD L. 15 S GP
460 COLLIERS CREEK RD, WATKINSVILLE 30677

GALLIS, ANTHONY H. 15 ACT IM
715 WEST LAKE DR, ATHENS 30606
GARCIA, RUBEN E. 15 ACT FP
1580 PRINCE AVE, ATHENS 30606
GARDNER, EDWARD C., JR. 15 ACT IM,GE
1077 BAXTER ST, ATHENS 30606
GLENN, T. LAMAR 15 ACT IM
740 PRINCE AVE, ATHENS 30601
GREEN, JAMES A. 15 R GS
146 DEARING ST, ATHENS 30605
GREGORY, J. MICHAEL 15 ACT U
195 KING AVE, ATHENS 30601
HARDMAN, WILLIAM J. 15 ACT DBG
740 PRINCE AVE, ATHENS 30601
HARRIS, HERSCHEL B. 15 R GP
ATHENS GENERAL HOSPITAL, ATHENS 30601
HARRIS, ROBERT M. 15 ACT P
PD BDX 8046, ATHENS 30603
HAWK, THOMAS H., JR. 15 ACT GS
740 PRINCE AVE, ATHENS 30601
HAYS, WILLIAM A., JR. 15 ACT P,CHP
PD BOX 712, ATHENS 30603
HENDRIX, NANCY C. 15 ACT PD
1010 PRINCE AVE, ATHENS 30606
HERRIN, E.V. 15 ACT DBG
740 PRINCE AVE, ATHENS 30601
HILL, JOHN B. 15 ACT OBG
740 PRINCE AVE, ATHENS 30601
HINTON, GOLDEN S. 15 ACT DPH
PD BDX 5518, ATHENS 30604
HOLBROOK, WILLIAM H., JR. 15 ACT R
797 CDBB ST, ATHENS 30601
HOLMES, WILLIAM C. 15 ACT FP
740 PRINCE AVE, ATHENS 30601
HORN, WARREN B. 15 ACT AN
PO BOX 6294, ATHENS 30604
HORNE, KENNETH W. 15 ACT R
1010 PRINCE AVE, ATHENS 30601
HU, HSHI YUNG 15 ACT FP
PO BDX 186, CDMER 30629
HUBRICH, LEON R. 15 ACT DRS
1000 HAWTHDRNE AVE, ATHENS 30610
HUNT, LOREN W., JR. 15 ACT IM,PUD
1010 PRINCE AVE, ATHENS 30606
HURTEAU, JOHN E. 15 ACT PS
1010 PRINCE AVE, ATHENS 30606
KELLER, A. PAUL, JR. 15 ACT OT,DPH
1010 PRINCE AVE, ATHENS 30606
KELLER, ALEXANOER P. 15 ACT OPH
1010 PRINCE AVE, ATHENS 30606
KELLEY, ROBERT E., JR. 15 ACT OBG
740 PRINCE AVE, ATHENS 30601
KIAS, THOMAS N., JR. 15 ACT IM
1010 PRINCE AVE, ATHENS 30601
KWON, OH BONG 15 ACT PD
1010 PRINCE AVE, ATHENS 30601
LEFFERT, ROBERT L. 15 ACT PTH
ST MARYS HDSPITAL, ATHENS 30606
LEWIS, EDWARD L., JR. 15 ACT D
1077 BAXTER ST, ATHENS 30601
LOCKMAN, DAVID S. 15 ACT IM
700 DGLETHORPE, ATHENS 30606
LUCAS, STEPHEN K. 15 ACT IM
1010 PRINCE AVE #112, ATHENS 30606
LYONS, THOMAS L. 15 ACT DBG
740 PRINCE AVE, ATHENS 30601
MAGILL, DANIEL H. 15 ACT CD
700 OGLETHDRPE AVE, ATHENS 30606
MAXWELL, G. DAVIO 15 ACT GS
1010 PRINCE AVE, ATHENS 30606
MAYBERRY, WILLIAM S. 15 ACT FP
120 WDDDLANDS DR, WATKINSVILLE 30677
MCDONALD, J.J. 15 ACT GS
740 PRINCE AVE, ATHENS 30601
MCELHANNON, F.M. 15 ACT GS
740 PRINCE AVE, ATHENS 30601
MCELHANNON, FAYETTE M., JR. 15 ACT DRS
1000 HAWTHORNE AVE, ATHENS 30610
MCPHERSON, JOHN H.T. 15 R GS
350 TALLASSEE FARM DR, ATHENS 30606
MEDDERS, LARRY L. 15 ACT ORS
125 KING AVE, ATHENS 30610
MERCER, CYNTHIA A. 15 ACT OBG
740 PRINCE AVE, ATHENS 30601
MIDDENDORF, WAYNE F. 15 ACT IM,PUD
1010 PRINCE AVE #112, ATHENS 30606
MILLER, JAMES S. 15 ACT IM
700 OGLETHDRPE AVE, ATHENS 30601
MONTGOMERY, THOMAS A. 15 ACT GS
1010 PRINCE AVE, ATHENS 30606
MORRIS, CLELL V. 15 ACT IM,N
2090 PRINCE AVE, ATHENS 30606
MORRISON, JAMES P. 15 ACT PD
1010 PRINCE AVE, ATHENS 30606
MULHERIN, WILLIAM B. 15 ACT DRS
125 KING AVE, ATHENS 30601
MUSE, A.O., JR. 15 ACT GS
740 PRINCE AVE, ATHENS 30601
NEIGHBORS, J.B., JR. 15 R IM
1010 PRINCE AVE, ATHENS 30601
NEUFELD, JOCELYN R. 15 R AN
135 GATEWDDD PL, ATHENS 30606
NEWLAND, HILLARY R. 15 ACT PTH
ATHENS GENERAL HOSP, ATHENS 30606
NIX, DILLARD L. 15 ACT OTO
1010 PRINCE AVE, ATHENS 30606
NOVEY, EOWARO S. 15 ACT N
2090 PRINCE AVE, ATHENS 30606
OUZTS, HARVEY 15 ACT CD
700 OGLETHDRPE AVE, ATHENS 30601
PALMER, JACK R. 15 ACT FP
1010 PRINCE AVE E, ATHENS 30601
PAYNE, ROBERT A. 15 ACT U
195 KING AVE, ATHENS 30601
PILON, ROBERT N. 15 ACT AN
111 WHIPPDDRWILL PL, ATHENS 30605
POWELL, JOHN L. 15 ACT GYN
740 PRINCE AVE, ATHENS 30601
RANDOLPH, R.H. 15 ACT GS
740 PRINCE AVE, ATHENS 30601
READ, SILAS C., JR. 15 ACT OPH
PO BOX 5518, ATHENS 30604
RITTER, LINDA B. 15 ACT AN
775 RIVERHILL DR, ATHENS 30606
ROBINSON, RALEIGH M. 15 ACT ORS
125 KING AVE, ATHENS 30610
SHAH, KAUSHIK S. 15 ACT OBG
1077 BAXTER ST, ATHENS 30606
SHAH, NARENDRA K. 15 ACT R
1199 PRINCE AVE, ATHENS 30613
SHEFFIELO, PHILIP 15 ACT OTO
1010 PRINCE AVE, ATHENS 30601
SHIFLET, ROBERT E. 15 R U
165 CEDAR CREEK DR, ATHENS 30605
SIGMAN, CHENEY C. 15 ACT PD
116 WODDLANDS RD, WATKINSVILLE 30677
SMITH, HENRY M. 15 ACT N
2090 PRINCE AVE, ATHENS 30606
SMITH, JAMES L. 15 ACT DBG
740 PRINCE AVE, ATHENS 30601
SMITH, JERRY O. 15 ACT R
ST MARYS HOSPITAL, ATHENS 30613
SMITH, REUBEN J. 15 ACT OBG
740 PRINCE AVE, ATHENS 30601
SRIVASTAVA, RAMESH K. 15 ACT PS
1077 BAXTER ST, ATHENS 30606
STEGEMAN, JOHN F. 15 R IM
1010 PRINCE AVE, ATHENS 30601
SWINGLE, ROGER L. 15 ACT DRS
125 KING AVE, ATHENS 30610
TALMADGE, HARRY E. 15 ACT GS
1077 BAXTER ST, ATHENS 30606
THOMAS, BOBBY MATHEW 15 ACT R
1230 BAXTER ST, ATHENS 30613
THOMAS, CHARLES 15 ACT GS
1010 PRINCE AVE, ATHENS 30606
THOMPSON, JAMES W. 15 ACT IM
1010 PRINCE AVE, ATHENS 30601
THOMPSON, RAMON C. 15 ACT U
225 SOUTH MILLEDGE AVE, ATHENS 30601
TILLMAN, BILLUPS P. 15 ACT DRS
125 KING AVE, ATHENS 30601
TRAYLOR, JAMES BOTHWELL 15 R OBG
175 ROCK GLENN RD, ATHENS 30606
TRICE, JOHN C. 15 ACT P
PO BDX 6105, ATHENS 30604
TSAO, SHU-YUN T. 15 ACT PD
1077 BAXTER ST, ATHENS 30606
TUMLIN, WILLIAM O. 15 ACT FP
CRAWFORD LEXINGTON MED CTR, LEXINGTON 30648
UTLEY, HENRY G. 15 ACT OPH
500 NORTH MILLEDGE AVE, ATHENS 30601
VAN DYCK, PHILIP G. 15 ACT R
ATHENS GENERAL HOSPITAL, ATHENS 30613
VRANA, MARK 15 ACT IM
1199 PRINCE AVE, ATHENS 30606
WEST, J. MICHAEL 15 ACT GE
1077 BAXTER ST, ATHENS 30606
WILLIAMS, JOSEPH P., JR. 15 ACT NS
PO BDX 6147, ATHENS 30604

16—CLAYTON-FAYETTE

ABELLERA, E.Q. 16 ACT GS
28 DIX-LEE'ON DR, FAIRBURN 30213
ACHECAR, FRED A. 16 ACT NS
33 SW UPPER RIVERDALE RD, RIVERDALE 30274
AJOY, VICENTE R. 16 ACT GS
259-B ARRDWHEAD BLVD, JONESBORO 30236
AKSTEIN, RICARDO B. 16 ACT OPH
PD BOX 859, RIVERDALE 30274
APANAY, MANOLO B. 16 ACT GS
250 ARROWHEAD BLVD, JONESBORO 30236
ASKEW, JAMES L. 16 ACT R
PO BOX 699, RIVERDALE 30274
AUPONT, PIERRE P.A. 16 ACT AN
597 CDNWAY FOREST DR, ATLANTA 30327
AUSTIN, HOWARO M. 16 ACT R
PO BOX 1255, RIVERDALE 30274
BANDERAS, JULIO C. 16 ACT ORS
113 UPPER RIVERDALE RD, RIVERDALE 30274
BELTRAN, SIMON E. 16 ACT
PD BOX 314, RIVERDALE 30274
BENDINS, KARLIS 16 ACT GP
607 FAYETTEVILLE RD, JONESBORO 30236
BERRY, NEIL C. 16 ACT DRS
33 SW UPPER RIVERDALE RD, RIVERDALE 30274
BISNO, OAVIO C. 16 ACT DPH
33 UPPER RIVERDALE RD, RIVERDALE 30274
BOWEN, ROBERT W. 16 ACT DBG
181 SW UPPER RIVERDALE RD, RIVERDALE 30274
BRUSMAN, HAROLO P. 16 ACT PTH
33 SW UPPER RIVERDALE RD, RIVERDALE 30274
BUSEY, T.J. 16 ACT U
225 WEST LANIER AVE, FAYETTEVILLE 30214
CASTILLO, REUBEN 16 ACT FP
217 ARROWHEAD BLVD, JDNESBORO 30236
CHEN, GUEY-CHING LAI 16 ACT GP
6670 MERCHANTS WAY, MDRROW 30260
CHEN, YEE C. 16 ACT ORS
6670 MERCHANTS WAY, MDRROW 30260
CHEVRES, FRANK, MD FACS 16 ACT DRS
113 UPPER RIVERDALE RD, RIVERDALE 30274
COHEN, LAWRENCE 16 ACT OBG
33 SW UPPER RIVERDALE RD, RIVERDALE 30274
DAVIS, MATTHEW E. 16 ACT DTO
33 SW UPPER RIVERDALE RD, RIVERDALE 30274

OINNERSTEIN, ALLAN J. 16 ACT OBG
29 SW UPPER RIVERDALE RD, RIVERDALE 30274
DRAKE, HENRY C. 16 ACT FP
805 SUMMIT NORTH DR, ATLANTA 30324
OUNBAR, ERNEST A., JR. 16 ACT PD
1035 MAIN ST, FOREST PARK 30050
DUTT, CYRIL P. 16 ACT GS
6507 PROFESSIDNAL PL, RIVERDALE 30274
ELSAHY, NABIL IBRAHIM 16 ACT PS
6524 PROFESSIONAL PL, RIVERDALE 30274
EVANS, ARTHUR R. 16 ACT GP
3681 AUDITORIUM WAY, COLLEGE PARK 30337
FEINSMITH, LESLIE M. 16 ACT NEP
150 MEDICAL WAY STE A, RIVERDALE 30274
FERNANOEZ, ANORES R. 16 ACT FP
195 UPPER RIVERDALE RD, RIVERDALE 30274
FREIREICH, RONALD 16 ACT CD
29 SW UPPER RIVERDALE RD, RIVERDALE 30274
FRIST, STEPHEN 16 ACT PTH
11 SW UPPER RIVERDALE RD, RIVERDALE 30274
GERSON, EOWIN STEVEN 16 ACT R
33 UPPER RIVERDALE RD, RIVERDALE 30274
GIMBEL, KENNETH S. 16 ACT CD
29 SW UPPER RIVERDALE RD, RIVERDALE 30274
GLAOSTONE, NEIL S. 16 ACT OBG
237 UPPER RIVERDALE RD, RIVERDALE 30274
GOLOSANO, CARL S. 16 ACT IM
217 ARROWHEAD BLVD CT C, JONESBORO 30236
GOLOSTEIN, JOEL A. 16 ACT PD
29 SW UPPER RIVERDALE RD, RIVERDALE 30274
GOMEZ, MIGUEL R. 16 ACT AN
MDRGAN'S MILL RD RT 2, SENDIA 30276
HADLEY, ELIZABETH 16 ACT R
PO BOX 699, RIVERDALE 30236
HARRISON, CLYOE C., JR. 16 ACT GS
1019 ASTOR AVE, FOREST PARK 30050
HARTLEY, S.T. 16 ACT EM
33 SW UPPER RIVERDALE RD, RIVERDALE 30274
HENORY, CHARLES H. 16 ACT P
3540 COCHISE DR NW, ATLANTA 30339
HOWELL, DOUGLAS E. 16 ACT GS
33 SW UPPER RIVERDALE RD, RIVERDALE 30274
HWANG, STEVE K. 16 ACT GS
PO BOX 590, RIVERDALE 30274
JOHNSON, CHARLES G. 16 ACT FP
217 MEDICAL WAY, RIVERDALE 30274
JUNG, HAEJA K. 16 ACT AL
251 MEDICAL WAY STE B, RIVERDALE 30274
JUNG, HEE C. 16 ACT AN
1262 WICKER CT, RIVERDALE 30296
KASHLAN, MALAKA AL-AZEM 16 ACT AN
409 ARROWHEAD BLVD BLDG A, JONESBDRD 30236
KATZ, MYRON M. 16 ACT OBG
259 ARROWHEAD BLVD, JDNESBORO 30236
KELLER, JOHN A. 16 ACT FP
100 NORTH PARK DR, FAYETTEVILLE 30214
KIM, PIL KWAN 16 ACT AN
8406 CREEKRIDGE CIR, RIVERDALE 30296
KIM, SOO-IL 16 ACT IM
1019 ASTDR AVE, FOREST PARK 30050
KREIDER, ROONEY N. 16 ACT PD
1035 MAIN ST, FDREST PARK 30050
KUNKES, JEFFREY A. 16 ACT DTO
6507 PROFESSIDNAL PL, RIVERDALE 30274
KUPCUOGLU, ERDAL H. 16 ACT DTO
217-C ARROWHEAD BLVD, JONESBORO 30236
LANO, WILLIAM C., JR. 16 ACT DR
119 UPPER RIVERDALE RD, RIVERDALE 30274
LEVY, ROBERT M. 16 ACT R
PD BDX 1255, RIVERDALE 30274
LEYVA, JOSE S. 16 ACT OBG
189 MEDICAL WAY, RIVERDALE 30274
LIEBMAN, PAUL H. 16 ACT IM
217 ARRDWHEAD BLVD, JONESBORD 30236
LIMEHOUSE, WALTER E., JR. 16 ACT PTH
33 UPPER RIVERDALE RD S22, RIVERDALE 30274
LIPSETT, NATHAN W. 16 ACT IM
29 SW UPPER RIVERDALE RD, RIVERDALE 30274
LOPEZ, HECTOR H., JR. 16 ACT IM
33 SW UPPER RIVERDALE RD, RIVERDALE 30274
LOPEZ, ORLANDO O. 16 ACT U
2739 FELTON DR, EAST POINT 30344
LUKE, B.D. 16 ACT FP
6103 NORTH MAIN ST, MDRROW 30260
MALLARI, RAYMUNOO T. 16 ACT IM
238 PROFESSIONAL CT, RIVERDALE 30274
MARTIN, WILLIAM O. 16 ACT OBG
189 MEDICAL WAY STE B, RIVERDALE 30274
MCCLELLAN, M.M., JR. 16 ACT PD
1035 MAIN ST, FOREST PARK 30050
MCMURRAY, ARTHUR A. 16 ACT GS
33 SW UPPER RIVERDALE RD, RIVERDALE 30274
MEOINA, LEONAROO H. 16 ACT U
217 UPPER RIVERDALE RD, RIVERDALE 30274
MERLIN, HARVEY E. 16 ACT U
29 SW UPPER RIVERDALE RD, RIVERDALE 30274
MOHAN, BH KRISHNA 16 ACT IM
6507 PROFESSIONAL PL, RIVERDALE 30274
NAIOU, SARVESWAR I. 16 ACT ORS
6507 PROFESSIONAL PL STE C, RIVERDALE 30274
NAIDU, SUBRAMANYAM K. 16 ACT IM
PO BDX 1286, RIVERDALE 30274
NAIR, RADHAKRISHNAN V. 16 ACT ORS
4939 RIVERDALE RD, ATLANTA 30337
NICHOLSON, F. PETER 16 ACT U
29 SW UPPER RIVERDALE RD, RIVERDALE 30274
PENG, VINCENT 16 ACT D
155 MEDICAL WAY, RIVERDALE 30274
PIYASENA, HARRY G. 16 ACT IM
29 SW UPPER RIVERDALE RD, RIVERDALE 30274
PLEMONS, MICHAEL R. 16 ACT DR
PO BOX 699, RIVERDALE 30274
QUILALA, EMILIANO P. 16 ACT GS
252 ARROWHEAD BLVD, JONESBORO 30236
RATHUR, BABER ZAHEER 16 ACT EM
181 SW UPPER RIVERDALE RD, RIVERDALE 30274
REOOY, ITHAMUKKALA J. 16 ACT GS
6507 PRDFESSIONAL PL STE B, RIVERDALE 30274
RILEY, WELLS 16 ACT FP
151 WEST MILL, JONESBORO 30236
RUBENSTEIN, ARNOLO B. 16 ACT U
29 SW UPPER RIVERDALE RD, RIVERDALE 30274
SABA, JOSEPH N. 16 ACT N
1135 HUDSDN BRIDGE RD, STOCKBRIDGE 30281
SAMS, FERROL A., III 16 ACT IM
675 NORTH JEFF DAVIS DR, FAYETTEVILLE 30214
SAMS, FERROL A., JR. 16 ACT FP
675 NORTH JEFF DAVIS, FAYETTEVILLE 30214
SAMS, HELEN F. 16 ACT GP
675 JEFF DAVIS, FAYETTEVILLE 30214
SAMS, JAMES C. 16 ACT IM
675 NORTH JEFF DAVIS DR, FAYETTEVILLE 30214
SARANGI, SARUDIN J.N. 16 ACT RHU
238 PROFESSIONAL CT, RIVERDALE 30274
SHEAR, GLENN S. 16 ACT OPH
33 UPPER RIVERDALE RD, RIVERDALE 30274
SHIN, YOUNG SHIK 16 ACT PD,A
1135 HUDSON BRIDGE RD, STOCKBRIDGE 30281
SOOD, PRAN N. 16 ACT ORS
4939 RIVERDALE RD STE 100, ATLANTA 30337
STAPPENBECK, RICHARD A. 16 ACT N
237 MEDICAL WAY, RIVERDALE 30274
STONE, ALBERT LAWRENCE 16 ACT PD
1035 MAIN ST, FOREST PARK 30050
TAKAGI, LUIS RAUL 16 ACT OBG
189 MEDICAL WAY STE B, RIVERDALE 30274
TAN, MIKE Y. 16 ACT AN
233 PLANTATIDN DR, RIVERDALE 30296
TULEY, CATHLEEN HARTMAN 16 ACT EM
PD BDX 314, RIVERDALE 30274
TULEY, R. DAVID 16 ACT GS
33 SW UPPER RIVERDALE RD, RIVERDALE 30274
WERNER, JACQUELINE H. 16 ACT PTH
11 SW UPPER RIVERDALE RD, RIVERDALE 30274
WILDSTEIN, GILBERT 16 ACT TS
29 SW UPPER RIVERDALE RD, RIVERDALE 30274
YU, ALBERT 16 ACT GS
248 ARROWHEAD BLVD, JONESBORO 30236
YUSUFJI, F.A. 16 ACT ORS
150 MEDICAL WAY STE D, RIVERDALE 30274
ZAKARIA, MAJED S. 16 ACT GS
PO BOX 1060, RIVERDALE 30274
ZLOCZOVER, GERARDO 16 ACT AN
409 ARROWHEAD BLVD, JODNESBORO 30236

17—COBB

AGRAZ, RODOLFO R. 17 ACT AN
3830 SOUTH CDBB DR STE 215-A, SMYRNA 30080
AGUILAR, AGUSTIN 17 ACT AN
5662 QUEENSBOROUGH DR NE, ATLANTA 30338
ALBUQUERQUE, L. JOHN OE 17 ACT GS
1406 DREXEL CT, MARIETTA 30067
ALPERN, ROBERT J. 17 ACT CHP
3995 SOUTH COBB DR, SMYRNA 30081
ANDREWS, CATHERINE S. 17 ACT FP
2931 SOUTH MAIN ST, KENNESAW 30144
BALLARD, DAVID C., III 17 ACT IM
652 CHURCH ST STE C, MARIETTA 30060
BAROACK, RICHARD A. 17 ACT CD
833 CAMPBELL HILL ST ' 460, MARIETTA 30090
BARNETT, J.C., JR. 17 ACT NS
776 CANTON RD, MARIETTA 30060
BATES, JACKSON H. 17 ACT IM
52 TOWER RD NW, MARIETTA 30060
BEECHAM, PAUL E. 17 ACT P
833 CAMPBELL HILL ST #440, MARIETTA 30090
BENSON, EARL B. 17 ACT AN
1500 BEAUMONT DR, KENNESAW 30144
BENSON, W.H., JR. 17 ACT IM
3188 ATLANTA ST SE, SMYRNA 30080
BERKOWITZ, ROBERT B. 17 ACT A
833 CAMPBELL HILL ST #490, MARIETTA 30090
BERMAN, MERRILL 17 ACT R
1676 MULKEY RD SW, AUSTELL 30001
BLANC, JAMES S. 17 ACT TS
1660 MULKEY RD STE A, AUSTELL 30001
BLUMENTHAL, JEROME B. 17 ACT IM
833 CAMPBELL HILL ST ' 460, MARIETTA 30090
BOWLES, F. NORMAN, JR. 17 ACT PTH
3950 AUSTELL RD, AUSTELL 30001
BRANCH, JOHN L., JR. 17 ACT IM
86 SDUTH COBB DR, MARIETTA 30063
BRETT, MILES ELI 17 ACT FP
2550 WINDY HILL RD STE 307, MARIETTA 30067
BRIGLEVICH, ROSE M. 17 ACT IM
3903 SOUTH COBB DR STE 207, SMYRNA 30080
BROCKS, COURTNEY CLARK 17 R US
4283 WOODLAND BRDOK DR NW, ATLANTA 30339
BROWN, LEONARO 17 ACT D
833 CAMPBELL HILL ST ' 260, MARIETTA 30090
BROWN, WILLIAM M. 17 ACT IM,CD
833 CAMPBELL HILL ST ' 360, MARIETTA 30060
BURLEIGH, BRUCE D. 17 ACT FP
37 MDDRE AVE NE, MARIETTA 30060
BURNS, JAMES B. 17 ACT R
737 CHURCH ST, MARIETTA 30061
CABOT, ANTHONY 17 ACT ORS
3903 SOUTH COBB DR STE 101, SMYRNA 30080
CABOT, WILLIAM 17 ACT ORS
3903 SOUTH COBB DR STE 101, SMYRNA 30080
CABRERA, LORENZO 17 ACT OBG
3903 SOUTH COBB DR #206, SMYRNA 30080
CAMBLOR, GONZALO 17 ACT PTH
COBB GENERAL HOSPITAL, AUSTELL 30001
CAMPBELL, OONALD H. 17 ACT GS
757 HAMPTDN PL, MARIETTA 30064

CARAS, THOMAS S. 17 ACT IM
641 CHURCH ST STE B, MARIETTA 30060
CARMAN, JOHN SCOTT 17 ACT P
3188 ATLANTA ST, SMYRNA 30080
CAUBLE, GEORGE 17 ACT FP
4803 MAIN ST, ACWORTH 30101
CAUSEY, ROBERT S., JR. 17 ACT PD
122 CHERRY ST, MARIETTA 30060
CELAYA, CARLOS L. 17 ACT U
3903 SOUTH COBB DR STE 212, SMYRNA 30080
CHANDLEE, ROBERT E. 17 ACT R
3865 STORY DR SW, MARIETTA 30060
CHEATHAM, JAMES S. 17 ACT P
3188 ATLANTA ST, SMYRNA 30080
CHRISTMAS, ROBERT C. 17 ACT OBG
STE F, MARIETTA 30060
CLARK, REMER Y., JR. 17 ACT FP
754 CHEROKEE ST, MARIETTA 30060
CLEMENTS, LARRY V. 17 ACT PD
833 CAMPBELL HILL ST #112, MARIETTA 30090
CLONTS, W.T. 17 ACT R
70 TOWER RD, MARIETTA 30061
COCHRAN, E.B. 17 ACT GS
641 CHURCH ST, MARIETTA 30060
COGGINS, ROBERT P. 17 ACT IM
787 CAMPBELL HILL ST, MARIETTA 30060
COHEN, RICHARD W. 17 ACT ORS
1620 MULKEY RD-UPPER LEVEL, AUSTELL 30001
COLQUITT, ALFRED O., III 17 ACT ORS
211 CHICOPEE DR, MARIETTA 30060
COLQUITT, ALFRED O., JR. 17 ACT OBG
615 ROSWELL ST, MARIETTA 30060
COLQUITT, HUGH S. 17 ACT PD
615 ROSWELL ST, MARIETTA 30060
COOPER, EUGENE A. 17 ACT FP
737 CHURCH ST, MARIETTA 30060
COOPER, J. THOMAS 17 ACT FP
1234 POWERS FERRY RD #102, MARIETTA 30067
COUSINS, WILLIAM L. 17 ACT IM
166 VANN ST, MARIETTA 30090
CRARY, ELY J. 17 ACT OPH
3903 SOUTH COBB DR, SMYRNA 30080
DANIEL, JAMES S. 17 ACT PUD
833 CAMPBELL HILL ST ' 200, MARIETTA 30090
DAVIS, WILKES H., JR. 17 ACT OPH
653 CHEROKEE ST NE, MARIETTA 30060
DAVIS, WILLIAM S. 17 ACT OBG
#5A, AUSTELL 30001
DE LEMOS, GASTON P. 17 ACT P
833 CAMPBELL HILL ST NE, MARIETTA 30090
DELLINGER, RAY E. 17 ACT GS
3001 SOUTH COBB DR SE, SMYRNA 30080
DESAI, USHA P. 17 ACT OBG
1660 MULKEY RD STE D, AUSTELL 30001
DOXEY, CLEM M., JR. 17 ACT D
114 CHERRY ST 'E, MARIETTA 30090
DOZIER, FRED A 17 ACT OS
2550 WINDY HILL RD STE 202, MARIETTA 30067
DUBOSE, LIGE MOULTRIE 17 ACT OPH
833 CAMPBELL HILL ST #380, MARIETTA 30090
DUNCAN, ROY G. 17 ACT PD
74 MEDICAL SQUARE, MARIETTA 30060
ESPY, GOODMAN B., III 17 ACT OBG
72 PLAZA WAY, MARIETTA 30060
ESPY, PAUL D. 17 ACT D
114 CHERRY ST STE E, MARIETTA 30090
FAULK, CARL F. 17 ACT AN
PO BOX 7449, MARIETTA 30065
FEINERMAN, LOIS K. 17 ACT D
1975 NORTH PARK PL STE 100, ATLANTA 30339
FEINERMAN, MICHAEL B. 17 ACT PS
1975 NORTH PARK PL STE 100, ATLANTA 30339
FERNANDEZ, JOSE M. 17 ACT PD
2550 WINDY HILL RD STE 109, MARIETTA 30067
FERRARI, DURVAL A. 17 ACT DR
3949 SOUTH COBB DR, SMYRNA 30080
FINCH, CHARLES S., JR. 17 ACT AN
3201 RIDGEWOOD RD NW, ATLANTA 30327
FINEMAN, STANLEY M. 17 ACT A
833 CAMPBELL HILL ST ' 490, MARIETTA 30090
FINKELMAN, DAVID 17 ACT IM,GE
1001 THORNTON RD, L02, LITHIA SPRINGS 30057
FISHER, GILBERT F., JR. 17 ACT OBG
41 MARGARET AVE, MARIETTA 30060
FLEMING, MICHAEL T. 17 ACT NS
1680 MULKEY RD STE B, AUSTELL 30001
FLETCHER, MELVIN R. 17 ACT PD
833 CAMPBELL HILL #360, MARIETTA 30090
FORTSON, LUTHER G., JR. 17 ACT IM
108 MARGARET AVE, MARIETTA 30060
FOWLER, R.W., JR. 17 ACT PD
680 CHURCH ST, MARIETTA 30060
GALLOWAY, GEORGE W., JR. 17 ACT FP
140 RIVER COURT PKY NW, ATLANTA 30328
GERSON, GORDON N. 17 ACT ORS
1668 MULKEY RD STE E, AUSTELL 30001
GHORASHI, BIJAN 17 ACT R
5520 GLEN ERROL RD, ATLANTA 30327
GIBBONS, WILLIAM S. 17 ACT ORS
211 CHICOPEE DR, MARIETTA 30060
GILLETT, BRUCE M. 17 ACT N
522 NORTH AVE, MARIETTA 30060
GIMPEL, AMNON 17 ACT P
1975 NORTH PARK PL STE 200, ATLANTA 30339
GINGREY, JOHN P. 17 ACT OBG
STE F, MARIETTA 30060
GISNESS, ROBERT A. 17 ACT EM
5406 TREELODGE PKY, DUNWOODY 30338
GLASS, CLARK H. 17 ACT ORS
652 CHURCH ST, MARIETTA 30060
GLUCKMAN, RICHARD 17 ACT N
1660 MULKEY RD, AUSTELL 30001
GOLDSTEIN, MARTIN I. 17 ACT D
3001 SOUTH COBB DR SE, SMYRNA 30080
GOODLET, JAMES S. 17 ACT U
660 CHEROKEE ST, MARIETTA 30060
GOULD, MARK A. 17 ACT P
3188 ATLANTA RD, SMYRNA 30080
GREENHOOD, GARY P. 17 ACT IM
833 CAMPBELL HILL ST #107, MARIETTA 30090
GREENWALD, LLOYD V. 17 ACT R
70 TOWER RD, MARIETTA 30060
GUR-LAVI, MEIR 17 ACT RHU
1668 MULKEY RD STE A, AUSTELL 30001
HAGOOD, M. FELTON 17 ACT CRS
805 CAMPBELL HILL ST, MARIETTA 30060
HAGOOD, M.M. 17 ACT GS
50 PLAZA WAY STE E, MARIETTA 30060
HAGOOD, RICHARD M. 17 ACT OBG
1790 MULKEY RD #5, AUSTELL 30001
HAILE, KENNETH L., JR. 17 ACT TR
PO BOX 3333, MARIETTA 30061
HAJ-MURAD, M. RAMZY 17 ACT U
4760 AUSTELL RD, AUSTELL 30001
HALDEMAN, LARRY W. 17 ACT PUD
833 CAMPBELL HILL ST, ' 200, MARIETTA 30090
HALL, GEORGE W. 17 ACT R
3950 AUSTELL RD, AUSTELL 30001
HALL, MAXWELL F., JR. 17 ACT R
70 TOWER RD, MARIETTA 30060
HALLBERG, STEVEN C. 17 ACT IM
PO BOX 39, AUSTELL 30001
HALLENBORG, BRUCE P. 17 ACT N
3903 SOUTH COBB DR, SMYRNA 30080
HAMMONDS, RICHARD LEE 17 ACT FP
4760 AUSTELL RD SW, AUSTELL 30001
HANAFI, MAGDI 17 ACT OBG
300 BOULEVARD NE, ATLANTA 30312
HARBOUR, JOHN H. 17 ACT IM
696 CONCORD RD SE, SMYRNA 30080
HARLEY, EUGENE L. 17 ACT IM
696 CONCORD RD SE, SMYRNA 30080
HARPER, ROBERT M. 17 ACT D
114 CHERRY ST STE E, MARIETTA 30090
HARRISON, GEORGE I. 17 ACT OTO
833 CAMPBELL HILL ST, MARIETTA 30090
HARVEY, DENNIS W. 17 ACT AN
1001 THORNTON RD, LITHIA SPRINGS 30057
HASTY, JEFFREY HARDING 17 ACT PD
4001 CANTON HWY STE 6, MARIETTA 30066
HENDERSON, CHARLES T. 17 ACT GS
737 CAMPBELL HILL ST, MARIETTA 30060
HENRY, WAIGHTS, III 17 ACT GS
805 CAMPBELL HILL ST, MARIETTA 30090
HERRERA, PASCUAL 17 ACT GS
222 CHEROKEE ST NE, MARIETTA 30060
HICKS, JOHN W., JR. 17 ACT GS
1902 LELAND DR, MARIETTA 30067
HIMOT, EDWARD D. 17 ACT NEP
833 CAMPBELL HILL ST ' 117, MARIETTA 30060
HIRSCH, ROBERT J. 17 ACT OBG
1230 JOHNSON FERRY RD, MARIETTA 30067
HOBSON, GERALD J. 17 ACT OPH
623 SOUTH MAIN ST, WOODSTOCK 30188
HODGES, JOHN M. 17 R GS
335 WHITLOCK AVE SW, MARIETTA 30064
HOLLADAY, WILLIAM E., JR. 17 ACT IM
787 CAMPBELL HILL ST, MARIETTA 30060
HOLTZ, NOEL 17 ACT N
522 NORTH AVE, MARIETTA 30060
HUTCHINSON, CHARLES L. 17 ACT PD
4001 CANTON HWY STE 6, MARIETTA 30066
HUTTENBACH, DIRK E. 17 ACT P
STE 440, MARIETTA 30090
INGLIS, E.P., JR. 17 ACT GP
50 PLAZA WAY STE B, MARIETTA 30060
ISRAEL, PHILIP Z. 17 ACT GS
833 CAMPBELL HILL ST ' 240, MARIETTA 30090
JABLOW, MITCHELL A. 17 ACT FP
2550 WINDY HILL RD STE 307, MARIETTA 30067
JACOBSON, ALAN I. 17 ACT PTH
PO BOX 665, MABLETON 30059
JENNINGS, C.M. 17 ACT IM
641 CHURCH ST, MARIETTA 30060
JOHNSTON, JACK H. 17 ACT IM
86 SOUTH COBB DR, MARIETTA 30063
JOSHI, Y.K. 17 ACT OBG
1001 THORNTON RD 3L5, LITHIA SPRINGS 30057
KAISER, RICHARD R. 17 ACT PD
3001 SOUTH COBB DR SE, SMYRNA 30080
KARASU, ZEYNEP 17 ACT PD
211 CHICOPEE DR, MARIETTA 30060
KHOURI, JOSEPH 17 ACT IM
2491 PACES FERRY RD, SMYRNA 30080
KIMMERLING, RICHARD W. 17 ACT GS
4760 AUSTELL RD, AUSTELL 30001
KING, OLIVER W. 17 ACT GS
3001 SOUTH COBB DR SE, SMYRNA 30080
KIRKPATRICK, JAMES L. 17 ACT AN
PO BOX 564, MARIETTA 30060
KLAUS, RICHARD M. 17 ACT ORS
1620 MULKEY RD UPPER LEVEL, AUSTELL 30001
KLEIMAN, SCOTT G. 17 ACT ORS
3910 AUSTELL RD, AUSTELL 30001
KLINGBEIL, ROBERT T. 17 ACT PM
KENNESTONE HOSPITAL, MARIETTA 30060
KNOX, JOHN D., JR. 17 ACT ORS
211 CHICOPEE DR, MARIETTA 30060
KRAUS, STEPHEN 17 ACT FP
1545 POWERS FERRY RD STE I, MARIETTA 30067
KUMIN, GERALD D. 17 ACT IM
833 CAMPBELL HILL RD ' 340, MARIETTA 30090
KYBURZ, BRUCE A. 17 ACT U
660 CHEROKEE, MARIETTA 30060
LAMBERT, ROBERT Y. 17 ACT GS
2701 SUMMERS ST, KEWNNESAW 30144
LAYNE, WILLIAM T. 17 ACT OBG
#5A, AUSTELL 30001

LESSLIE, WILLIAM P. 17 ACT IM
86 SOUTH COBB DR, MARIETTA 30063
LEVINE, ALLAN N. 17 ACT ORS
3910 AUSTELL RD STE 101, AUSTELL 30001
LEVINE, MICHAEL S. 17 ACT GE
2550 WINDY HILL RD STE 203, MARIETTA 30067
LIGON, WALTER M. 17 ACT OTO
444 FAIRGROUND ST, MARIETTA 30060
LINDSEY, MARK M. 17 ACT FP
4430 PACES BATTLE NW, ATLANTA 30327
LIPSON, ROBERT A. 17 ACT IM
166 VANN ST, MARIETTA 30090
LORENZ, MAX P. 17 ACT U
833 CAMPBELL HILL ST ' 290, MARIETTA 30090
LOTNER, GARY Z. 17 ACT A
2480 WINDY HILL RD STE 201, MARIETTA 30067
MAINOR, ROBERT 17 ACT FP
2874 KING ST SE, SMYRNA 30080
MALCOM, GEORGE E., JR. 17 ACT EM
1355 WOODSTOCK RD, ROSWELL 30075
MALENBAUM, BRUCE T. 17 ACT OTO,MFS
1790 MULKEY RD STE 7, AUSTELL 30001
MALONE, ELLIS L. 17 ACT IM
3910 AUSTELL RD STE 203, AUSTELL 30001
MANNING, JAMES H. 17 ACT GS
50 PLAZA WAY, MARIETTA 30060
MANUS, RICHARD C. 17 ACT FP
1668 MULKEY RD, AUSTELL 30001
MARKLE, C. DAVID 17 ACT IM
3910 AUSTELL RD STE 203, AUSTELL 30001
MATHIS, W.H., JR. 17 ACT R
70 TOWER RD, MARIETTA 30060
MAY, STEPHEN C., JR. 17 ACT FP
2931 SOUTH MAIN ST, KENNESAW 30144
MCBRIDE, WALTER W. 17 ACT IM
52 TOWER RD, MARIETTA 30060
MCCLURE, E. RUTH 17 ACT OBG
732 CHEROKEE ST, MARIETTA 30060
MCCORD, GEORGE, JR. 17 ACT R
70 TOWER DR, MARIETTA 30060
MCKERNAN, J. BARRY 17 ACT GS
130 VANN ST STE 220, MARIETTA 30060
MCKINNON, FRANK W. 17 ACT ORS
652 CHURCH ST, MARIETTA 30060
MCLARTY, W. THERON, JR. 17 ACT P
3985 SOUTH COBB DR, SMYRNA 30080
MCLEAN, WILLIAM R. 17 ACT PD
74 MEDICAL SQ, MARIETTA 30060
MCLEOD, HUGH C., III 17 ACT ORS
211 CHICOPEE DR, MARIETTA 30060
MCNATT, JIM H. 17 ACT OPH
653 CHEROKEE ST, MARIETTA 30090
MEADERS, HENRY D. 17 ACT OBG
705 CAMPBELL HILL ST, MARIETTA 30060
MEADOWS, NOAH D., JR. 17 ACT IM
52 TOWER RD, MARIETTA 30060
MEIER, WALTER L. 17 ACT R
3865 STORY DR SW, MARIETTA 30060
MENDELSOHN, KEVIN B. 17 ACT OTO
1678 MULKEY RD STE F, AUSTELL 30001
MENDEZ, RUBEN A. 17 ACT P,CHP
3985 SOUTH COBB DR, SMYRNA 30080
MICHAELIDES, KYRIAKOS M. 17 ACT GE
1790 MULKEY RD STE 6-A, AUSTELL 30001
MIHALOVITS, KARL S. 17 ACT P
3188 ATLANTA ST SE, SMYRNA 30080
MILLER, GARY M. 17 ACT PD,N
522 NORTH AVENUE, MARIETTA 30060
MIMS, GEORGE T., JR. 17 ACT IM
787 CAMPBELL HILL ST, MARIETTA 30060
MITCHELL, MARVIN M. 17 ACT ORS
3910 AUSTELL RD, AUSTELL 30001
MITCHELL, P. ROBERT 17 ACT OBG
833 CAMPBELL HILL ST ' 250, MARIETTA 30090
MITCHELL, W.C. 17 ACT FP
3040 ATLANTA ST SE, SMYRNA 30080
MOLINARI, VINCENT G. 17 ACT OBG
3903 SOUTH COBB DR, SMYRNA 30080
MORELL, RENE A. 17 ACT OBG
3903 SOUTH COBB DR, SMYRNA 30080
MULL, MICHAEL S. 17 ACT OBG
114 CHERRY ST STE F, MARIETTA 30060
MULLINIKS, ROBERT C., JR. 17 ACT OBG
1790 MULKEY RD STE 5-A, AUSTELL 30001
MULLINS, SPENCER G. 17 ACT GS
805 CAMPBELL HILL ST, MARIETTA 30060
MURRAY, DARRELL W. 17 ACT FP
1221 OLD POWDER SPRINGS RD, MABLETON 30059
MUSARRA, E.A. 17 ACT FP
754 CHEROKEE ST, MARIETTA 30060
MUSARRA, E.A., II 17 ACT PS
833 CAMPBELL HILL ST ' 116, MARIETTA 30090
MUSSER, ELLYN ZUNKER 17 ACT PD
2480 WINDY HILL RD STE 303, MARIETTA 30067
NAZLI, MEHMET H. 17 ACT AN
1790 MULKEY RD STE 1, AUSTELL 30001
NEGRIN, NEIL J. 17 ACT ORS
3910 AUSTELL RD STE 101, AUSTELL 30001
NEWTON, MAURY CLAIBORNE, JR. 17 ACT IM
787 CAMPBELL HILL ST, MARIETTA 30060
NICHOLS, EVANS J. 17 ACT OBG
705 CAMPBELL HILL ST, MARIETTA 30060
NOLEN, JOHN HENRY, JR. 17 ACT OPH
653 CHEROKEE ST, MARIETTA 30060
OLIVER, IZHAK 17 ACT IM,END
1001 THORNTON RD, LITHIA SPRINGS 30057
ORAN, ERDOGAN 17 ACT CD
4426 AUSTELL RD, AUSTELL 30001
OSMON, CARLOS A. 17 ACT IM
1790 MULKEY RD STE 4, AUSTELL 30001
PALMER, FRED L. 17 ACT R
3865 STORY DR, MARIETTA 30060
PARHAM, ROBERT E. 17 ACT N
833 CAMPBELL HILL ST ' 430, MARIETTA 30090
PATEL, THAKOR B. 17 ACT AN
BOX 517, AUSTELL 30001
PATTERSON, WILLIAM C. 17 R GS
3991 RIDGE RD SE, SMYRNA 30080
PAUSA, SERGIO G. 17 ACT GS
5367 GORDON RD EXT, MABLETON 30059
PAYNE, PAUL J. 17 ACT ORS
652 CHURCH ST, MARIETTA 30060
PEEL, JESSE ROBERT 17 ACT P
3188 ATLANTA ST SE, SMYRNA 30080
PENA, LEOPOLD I. 17 ACT GS
3812 AUSTELL RD, MARIETTA 30060
PENNINGTON, JOHN A. 17 ACT AN
3112 BUNKER HILL DR, MARIETTA 30060
PERRY, BYRON L. 17 ACT OTO,PS
833 CAMPBELL HILL ST ' 115, MARIETTA 30090
PHILLIPS, JOE M., JR. 17 ACT OBG
180 CHEROKEE ST, MARIETTA 30060
POPE, EUGENE J. 17 ACT CD
1001 THORNTON RD, L07, LITHIA SPRINGS 30057
PORTER, HARRY, JR. 17 ACT P
2700 CUMBERLAND PKY STE 320, ATLANTA 30339
PRICE, JOHN W. 17 ACT FP
1230 JOHNSON FERRY RD, MARIETTA 30067
PRINCE, ALAN D. 17 ACT N
522 NORTH AVE, MARIETTA 30060
RANDALL, ALFRED H., JR. 17 ACT IM
641 CHURCH ST, MARIETTA 30060
RAY, MICHAEL K. 17 ACT EM
677 CHURCH ST, MARIETTA 30060
RE, PETER K. 17 ACT N
522 NORTH AVE, MARIETTA 30060
REES, KLAUS O. 17 ACT CD
1001 THORNTON RD 107, LITHIA SPRINGS 30057
REILLY, ENOS J. 17 R OBG
705 CAMPBELL HILL ST, MARIETTA 30060
REISH, MARTIN L. 17 ACT PD
2550 WINDY HILL RD STE 109, MARIETTA 30062
REY, CHARLES J., JR. 17 ACT GS
4399 AUSTELL RD, AUSTELL 30001
ROBERTS, JOHN E. 17 ACT FP
1790 MULKEY RD STE 8-A, AUSTELL 30001
ROBERTSON, PAUL A. 17 ACT OS
PO BOX 7956, MARIETTA 30065
ROBERTSON, WILLIAM T. 17 ACT U
823 CAMPBELL HILL ST, MARIETTA 30060
ROCHE, ROBERT R. 17 ACT R
3865 STORY DR SW, MARIETTA 30060
ROPER, RONALD P. 17 ACT U
823 CAMPBELL HILL ST, MARIETTA 30060
ROSEN, RONALD 17 ACT U
1620 MULKEY RD, AUSTELL 30001
ROSENBLOOM, SEYMOUR J. 17 ACT IM
833 CAMPBELL HILL ST, MARIETTA 30090
ROSS, JOHN W. 17 ACT PTH
677 CHURCH ST, MARIETTA 30060
ROSSNER, STEPHEN D. 17 ACT CD
670 CHEROKEE ST, MARIETTA 30060
RUDE, JOE CHRISTOPHER 17 ACT R
3865 STOREY DR SW, MARIETTA 30060
RUSHTON, HARRY G., JR. 17 ACT U
660 CHEROKEE ST, MARIETTA 30060
SANDBERG, JOHN 17 ACT PD
969 CHEROKEE RD STE L, SMYRNA 30080
SANDERS, GERALD E. 17 ACT OPH
653 CHEROKEE ST, MARIETTA 30060
SAYE, WILLIAM B. 17 ACT OBG
792 CHURCH ST STE 4, MARIETTA 30060
SCHLACHTER, LAWRENCE B. 17 ACT NS
1057 FIELDING WAY, MARIETTA 30067
SCHMIDT, DAVID M. 17 ACT U
823 CAMPBELL HILL ST, MARIETTA 30060
SCHMIDT, F.K. 17 ACT U
823 CAMPBELL HILL ST, MARIETTA 30060
SEARCY, ASHBURN P. 17 ACT AN
6430 RIVER CHASE CIR NW, ATLANTA 30328
SELMONOSKY, CARLOS A. 17 ACT TS
1660 MULKEY RD STE A, AUSTELL 30001
SESSIONS, ROBERT T. 17 ACT GS
811 CHURCH ST, MARIETTA 30060
SHAPIRO, STANLEY T. 17 ACT OTO
2550 WINDY HILL RD #106, MARIETTA 30067
SHAW, MATTHEW C. 17 ACT AN
PO BOX 1547, MARIETTA 30061
SHERRER, DOROTHY 17 ACT P
3188 ATLANTA ST SE, SMYRNA 30080
SHERRER, WEBSTER A. 17 ACT PTH
833 CAMPBELL HILL ST ' 111, MARIETTA 30090
SIGAL, HOWARD MARVIN 17 ACT PD
3001 SOUTH COBB DR SE, SMYRNA 30080
SIMONE, GREGORY L. 17 ACT CD
670 CHEROKEE ST, MARIETTA 30060
SISTRUNK, T.LEWIS 17 ACT R
600 WEST MEMORIAL DR, DALLAS 30132
SKEEL, DAVID A. 17 ACT U
2550 WINDY HILL RD STE 310, MARIETTA 30067
SMITH, DARIUS A. 17 ACT FP
625 WEST MEMORIAL DR, DALLAS 30132
SMITH, GARY L. 17 ACT OBG
1230 JOHNSON FERRY RD D-10, MARIETTA 30067
SMITH, SAMUEL R. 17 ACT AN
507 S KEELER WOODS DR, MARIETTA 30064
SOLODAR, SEYMOUR O. 17 ACT P
3985 SOUTH COBB DR STE 200, SMYRNA 30080
SOMERLOT, WARREN A. 17 ACT OBG
643 CAMPBELL HILL ST, MARIETTA 30060
SPANGLER, DENNIS LEE 17 ACT A
2480 WINDY HILL RD STE 201, MARIETTA 30067
SPRINGER, JACK S. 17 ACT FP
2903 RIVERMEADE DR, ATLANTA 30327
SPROUSE, JAMES H., JR. 17 ACT AN
PO BOX 7449, MARIETTA 30065
STALEY, IRVING T. 17 ACT OPH
653 CHEROKEE ST, MARIETTA 30060

STAPLETON, GERALD M. 17 ACT OTO
1790 MULKEY RD STE 7, AUSTELL 30001
STEPHENS, OAN B. 17 ACT OBG
140 VANN ST STE 300, MARIETTA 30060
STEPHENS, ROBERT O. 17 ACT PD
833 CAMPBELL HILL ST ' 112, MARIETTA 30090
STEWART, OEANNA B. 17 ACT PD
833 CAMPBELL HILL ST ' 270, MARIETTA 30090
STURKIE, THOMAS OTIS 17 ACT ORS
652 CHURCH ST, MARIETTA 30060
SUTTON, JEFFREY L. 17 ACT IM
833 CAMPBELL HILL ST ' 230, MARIETTA 30090
SWIFT, JONATHAN S. 17 ACT ORS
754 CHEROKEE ST, MARIETTA 30060
TALLMAN, JAMES M. 17 ACT R
814 HAMPTON PL, MARIETTA 30064
TANNER, JACK E. 17 ACT OBG
1200 ROSWELL RD, MARIETTA 30062
TARK, MARVIN O. 17 ACT AN
833 CAMPBELL HILL ST #460, MARIETTA 30090
TAYLOR, ROBERT P. 17 ACT OPH
833 CAMPBELL HILL ST #380, MARIETTA 30090
TEEM, MARTIN V., JR. 17 ACT IM
200 CHEROKEE ST, MARIETTA 30060
TEMPLETON, H. WAYNE 17 ACT FP
4755 KELLY CT, MABLETON 30059
TERMOTTO, DAVID WALTER 17 ACT AN
3530 BRIARCLIFF RD NE, ATLANTA 30345
THIBODEAUX, DAVID C. 17 ACT R
70 TOWER RD NW, MARIETTA 30060
TILIACOS, JOHN N. 17 ACT ORS
127 CHERRY ST, MARIETTA 30060
TINKELMAN, DAVID G. 17 ACT A
2480 WINDY HILL RD #201, MARIETTA 30067
TOOLE, JAMES C. 17 ACT OBG
643 CAMPBELL HILL ST, MARIETTA 30060
TOWNSENO, ROBERT M. 17 ACT FP
110 LEWIS DR, MARIETTA 30060
TRIPPE, JUDSON R., JR. 17 ACT PD
833 CAMPBELL HILL ST ' 112, MARIETTA 30090
TRYON, WILLIAM E. 17 ACT FP
1323-A ROSWELL RD, MARIETTA 30062
TUCKER, JOHN D. 17 ACT GS
805 CAMPBELL HILL ST, MARIETTA 30090
UDEL, MELVIN M. 17 ACT P,PM
3985 SOUTH COBB DR STE 110, SMYRNA 30080
UMPIERRE, JORGE E. 17 ACT PD
833 CAMPBELL HILL ST ' 360, MARIETTA 30090
UNDERWOOO, CHARLES R. 17 ACT GS
641 CHURCH ST, MARIETTA 30060
URRUTIA, R.V., JR. 17 ACT ORS
3903 SOUTH COBB DR STE 101, SMYRNA 30080
URRUTIA, ROSA C. 17 ACT FP
3903 SOUTH DR #209, SMYRNA 30080
VAN HOUTEN, JOHN B., JR. 17 ACT GP
PO BOX 7449, MARIETTA 30065
VANSANT, T.J., JR. 17 ACT IM
702 CHEROKEE ST, MARIETTA 30060
VARNAM, GERALO S. 17 ACT IM
PO BOX 105103, ATLANTA 30067
VAUGHAN, EDGAR ALLEN 17 ACT PD
74 MEDICAL SQ, MARIETTA 30060
WAKEFIELD, JOHN R. 17 R FP
4900 TIMBERLAND DR, MABLETON 30059
WALLACE, BILL L. 17 ACT FP
2480 WINDY HILL RD, MARIETTA 30067
WALTERS, STEVEN L. 17 ACT GS
805 CAMPBELL HILL ST, MARIETTA 30060
WARD, M. CAROLYN 17 ACT OBG
652 CHURCH ST STE D, MARIETTA 30060
WARNER, JOHN C., JR. 17 ACT PD
3001 SOUTH COBB DR SE, SMYRNA 30080
WARREN, JAMES E. 17 ACT AN
PO BOX 7449, MARIETTA 30065
WATSON, WILLIAM W. 17 ACT EM
677 CHURCH ST, MARIETTA 30060
WEBER, JONATHAN 17 ACT AN
833 CAMPBELL HILL ST ' 460, MARIETTA 30090
WEISMAN, EVAN B. 17 ACT IM
833 CAMPBELL HIL ST, MARIETTA 30090
WENER, JEFFREY ALLAN 17 ACT ORS
2550 WINDY HILL RD #304, MARIETTA 30067
WENER, ROBERT GOROON 17 ACT OPH
2550 WINDY HILL RD #303, MARIETTA 30067
WHYTE, HENRY J. 17 ACT D
1230 JOHNSON FERRY RD, MARIETTA 30067
WIELAND, WILLIAM F. 17 ACT P
1999 CLIFF VALLEY WAY, ATLANTA 30329
WILHELM, CHARLES C. 17 ACT IM
833 CAMPBELL HILL ST ' 230, MARIETTA 30090
WILLIAMS, MALCOLM H. 17 ACT IM
3001 SOUTH COBB DR SE, SMYRNA 30080
WILLIAMS, WILLIAM TALBERT 17 ACT IM
696 CONCORD RD, SMYRNA 30080
WINIARSKI, NILDA 17 ACT PTH
PO BOX 6, AUSTELL 30001
WOFFORD, BENJAMIN H., JR. 17 ACT PS
684 CHEROKEE ST, MARIETTA 30060
WRIGHT, STEPHEN C. 17 ACT CHP
2355 BOLTON RD NW, ATLANTA 30381
WRIGHT, THOMAS L. 17 ACT N
1680 MULKEY RD STE C, AUSTELL 30001
WYANT, JOHN R., JR. 17 ACT OBG
705 CAMPBELL HILL ST, MARIETTA 30060

18—COFFEE

ARUNACHALAM, KRISHNAN 18 ACT IM
PO BOX 1409, DOUGLAS 31533
BELL, EUGENE D. 18 R FP
PO BOX 1267, DOUGLAS 31533
BENSON, RICHARD L. 18 ACT R
BOX 1077, DOUGLAS 31533
GILLIARD, FRED E. 18 ACT FP
PO BOX 1308, DOUGLAS 31533
HARPER, MEREDITH 18 ACT OBG
PO BOX 1366, DOUGLAS 31533
JONES, MARY B. 18 ACT FP
3 ATLANTA AVE, HICHOLLS 31554
LIN, CHENG-HSIUNG 18 ACT OBG
PO BOX 1056, DOUGLAS 31533
MEEKS, CALVIN STEWART, JR. 18 ACT FP
PO BOX 367 OCILLA RD, DOUGLAS 31533
NATION, THOMAS C. 18 ACT PTH
PO BOX 1248, DOUGLAS 31533
PATEL, ARVIND M. 18 ACT U
PO BOX 1018, DOUGLAS 31533
RUDOLPH, STEPHEN J., JR. 18 R OM
702 NORTH GASKIN AVE, DOUGLAS 31533
STAPLETON, TOMMY K. 18 ACT FP
PO BOX 769, DOUGLAS 31533
VICKERS, OTIS R. 18 ACT GS
PO BOX 979, DOUGLAS 31533
WILLIAMS, JACK G. 18 ACT PD
PO BOX 568, DOUGLAS 31533
WILLS, WILLIAM R., JR. 18 ACT FP
PO BOX 32, DOUGLAS 31533

19—COLQUITT

ADCOCK, DAVID W. 19 ACT ORS
1414 SOUTH MAIN ST, MOULTRIE 31768
ALLEN, STEPHEN C. 19 ACT U
#2 HOSPITAL PK, MOULTRIE 31768
BROWN, WILLIAM O. 19 ACT PTH
COLQUITT CO MEMORIAL HOSP, MOULTRIE 31768
CONGER, P.D. 19 ACT FP
15 FIFTH AVE SW, MOULTRIE 31768
COPELAND, LANNY R. 19 ACT FP
PO BOX 2307, MOULTRIE 31768
ESTES, THOMAS L. 19 ACT GS
3004 SECOND ST SE, MOULTRIE 31768
FLYNN, JAMES T., JR. 19 ACT OTO
PO BOX 1530, MOULTRIE 31768
FOKES, ROBERT E., JR. 19 ACT OPH
PO BOX 1139, MOULTRIE 31768
GAY, FRANCIS M. 19 ACT FP
PO BOX 10, MOULTRIE 31768
GILOINER, KAROL 19 ACT GP
700 SOUTH MAIN ST, MOULTRIE 31768
GOLDHAGEN, HAVIVA 19 ACT GP
700 SOUTH MAIN ST, MOULTRIE 31768
HANEY, MICHAEL J. 19 ACT GS
3004 SECOND ST SE, MOULTRIE 31768
HARRIS, O.Q., III 19 ACT ORS
111 30TH AVE SE, MOULTRIE 31768
HARRISON, WALTER E. 19 ACT FP
711 SOUTH MAIN ST, MOULTRIE 31768
HOUSTON, G. COURTNEY 19 ACT GS
3004 SECOND ST SE, MOULTRIE 31768
JACKSON, EUGENE H. 19 ACT FP
PO BOX 2307, MOULTRIE 31768
JOINER, R.M. 19 ACT PD
1317 SOUTH MAIN, MOULTRIE 31768
KING, CHARLES RICHARD 19 ACT OBG
3011 FOURTH ST SE, MOULTRIE 31768
LACONTE, LEONARD P. 19 ACT R
BOX 608, MOULTRIE 31768
MCGINTY, W.R. 19 R U
RTE 4, MOULTRIE 31768
MCLEOD, JOHN W. 19 ACT GS
1323 SOUTH MAIN ST, MOULTRIE 31768
MORTON, ROBERT O. 19 ACT IM
717 SOUTH MAIN, MOULTRIE 31768
NEWTON, JOHN S. 19 ACT OPH
PO BOX 663, MOULTRIE 31776
PAULK, J.R. 19 R OPH
FAIRVIEW DR, MOULTRIE 31768
REESE, NORMAN O. 19 ACT AN
PO BOX 427, MOULTRIE 31768
ROGERS, EDWARD A., JR. 19 ACT OBG
3011 FOURTH ST SE, MOULTRIE 31768
STELLER, ROBERT T. 19 ACT OPH
2907 SOUTH MAIN ST, MOULTRIE 31768
TUCKER, JOHN P. 19 R FP
704 THIRD ST SW, MOULTRIE 31768
WHITTLE, MICHAEL H. 19 ACT R
PO BOX 608, MOULTRIE 31768

20—COWETA

ARNOLD, J.H. 20 ACT FP
PO BOX 279, NEWNAN 30263
BARRON, WILLIAM E., JR. 20 ACT IM
PO BOX 609, NEWNAN 30263
BASS, F. DONALD 20 ACT GS
PO BOX 609, NEWNAN 30263
BRYANT, JAMES M., JR. 20 ACT GP
32 JACKSON ST, NEWNAN 30263
BURNS, MATTHEW L. 20 ACT GS
PO BOX 609, NEWNAN 30264
CANKIR, KAMIL S. 20 ACT GP
PO BOX D, GRANTVILLE 30220
COLLINS, LEWIS R. 20 ACT IM
PO BOX 609, NEWNAN 30263
CUNANAN, LINOA C. 20 ACT IM
72 GREENVILLE ST #7, NEWNAN 30263
EATON, JAMES M., JR. 20 ACT U
103 WOODBINE CIR, NEWNAN 30263
FARMER, CHARLES W., JR. 20 ACT OTO
PO BOX 160, NEWNAN 30263
GILBERT, FREDERICK E. 20 ACT PTH
PO BOX 1301, NEWNAN 30264
GILES, JACKSON T. 20 ACT OPH
BOX 609, NEWNAN 30264

GLOVER, HOWARD C., JR. 20 ACT PD
6 BROWN ST, NEWNAN 30263
GLOVER, N.B. 20 ACT PD
6 BROWN ST, NEWNAN 30263
GRAHAM, THOMAS C. 20 ACT OBG
PO BOX 609, NEWNAN 30264
JARRARD, GEORGE T. 20 ACT IM
PO BOX 609, NEWNAN 30263
MACNABB, GEORGE M. 20 ACT IM
58 HOSPITAL RD STE 106, NEWNAN 30263
PARKS, JOSEPH W., JR. 20 ACT FP
PO BOX 609, NEWNAN 30264
POWELL, JACK H., JR. 20 ACT GS
PO BOX 609, NEWNAN 30263
SOSBY, JOHN T. 20 ACT OBG
215 JACKSON ST, NEWNAN 30264
SPEARS, ROBERT S. 20 ACT AN
60 HOSPITAL RD, NEWNAN 30263
SPIER, GEORGE E. 20 ACT AN
80 JACKSON ST, NEWNAN 30263
THOMASSON, JAMES J., JR. 20 ACT GS
PO BOX 609, NEWNAN 30263
THOMPSON, ROBERT F. 20 ACT OTO
PO BOX 1155, NEWNAN 30263
WALKER, DON C. 20 ACT GS
58 HOSPITAL RD STE 102, NEWNAN 30263
WELLS, JOHN G. 20 ACT IM
PO BOX 1099, NEWNAN 30264

21—DECATUR-SEMINOLE

BELLVILLE, CHARLES G. 21 R GS
1602 DOUGLAS DR, BAINBRIDGE 31717
BRECKENRIDGE, H.E., JR. 21 ACT FP
HOSPITAL CIR, DONALSONVILLE 31745
COCHRAN, J. SYDNEY 21 ACT IM,PD
PO BOX 385, BAINBRIDGE 31717
EHRLICH, M.A. 21 ACT PD
231 EAST BROUGHTON ST, BAINBRIDGE 31717
GIBSON, FRANK L. 21 ACT GS
PO BOX 525, BAINBRIDGE 31717
REYNOLDS, WILTON B., JR. 21 ACT FP
BOX 1075, BAINBRIDGE 31717
STAFFORD, CHARLES T. 21 ACT OBG
1323 EAST SHOTWELL ST, BAINBRIDGE 31717
STARLING, ROBERT J. 21 ACT FP
611 MORRIS AVE, DONALSONVILLE 31745
STEWART, CHARLES C. 21 ACT FP
PO BOX 128, DONALSONVILLE 31745
WALKER, CHARLES O. 21 ACT GS
PO BOX 1805, BAINBRIDGE 31717
WOODS, E. ASHBY 21 ACT FP
PO BOX 37, BAINBRIDGE 31717
ZILIS, JAMES J. 21 ACT OBG
PO BOX 933, BAINBRIDGE 31717

22—DEKALB

ADAN, ANIBAL 22 ACT AN
755 COLUMBIA DR STE 413, DECATUR 30030
AHN, SOO WONG 22 ACT IM
8 LAVISTA PERIMETER OFC PK, TUCKER 30084
ALLARD, CHARLES 22 ACT FP
755 COLUMBIA DR STE 302, DECATUR 30030
ALLEN, LEE T. 22 ACT U
755 COLUMBIA DR STE B, DECATUR 30030
ALMEROTH, ROBERT H., JR. 22 ACT FP
1462 MONTREAL RD STE 307, TUCKER 30084
AMATRIAIN, F.F. 22 ACT OBG
5040 SNAPFINGER WOODS DR, DECATUR 30035
ANDERSON, WILLIAM J. 22 ACT FP
755 COLUMBIA DR STE 333, DECATUR 30030
ANDREWS, H. GIBBS 22 ACT PDS
1901 CENTURY BLVD NE STE 11, ATLANTA 30345
APGAR, J. THOMAS 22 ACT D
1462 MONTREAL RD STE 203, TUCKER 30084
APPEL, SIDNEY D. 22 ACT GS
1462 MONTREAL RD STE 205, TUCKER 30084
ARNOLD, JOSEPH A. 22 ACT GP
2910 NORTH DRUID HILLS RD NE, ATLANTA 30329
ARONOVITZ, GERSON H. 22 ACT PD
2714 CLAIRMONT RD NE, ATLANTA 30329
ARTIME, MANUEL E. 22 ACT A
2191 NORTHLAKE PKY, TUCKER 30084
ATKINS, EARNEST C. 22 ACT GS
2910 NORTH DRUID HILLS RD, ATLANTA 30329
ATLURI, RAVATI 22 ACT IM
2754 NORTH DECATUR RD, DECATUR 30030
AVRET, EDWIN T. 22 ACT IM
4151 MEMORIAL DR 105-B, DECATUR 30032
AYRES, J. ALEXANDER 22 ACT OPH
542 CHURCH ST STE 232, DECATUR 30030
BAKAY, ROY A.E. 22 ACT GS,NS
1365 CLIFTON RD NE, ATLANTA 30322
BALL, HORACE C. 22 ACT OBG
755 COLUMBIA DR STE 503, DECATUR 30030
BALL, LARRY T. 22 ACT IM
2054-B LAWRENCEVILLE HWY, DECATUR 30033
BANTLY, THOMAS W. 22 ACT P
2754 NORTH DECATUR RD, DECATUR 30030
BARIA, WILLIAM H. 22 ACT IM
105 COLLIER RD NW STE 2050, ATLANTA 30309
BATH, NICHOLAS M. 22 ACT U
755 COLUMBIA DR STE B, DECATUR 30030
BEARD, CHARLENE H. 22 ACT PD
5565 MEMORIAL DR 'D, STONE MOUNTAIN 30083
BELCHER, WILLIAM T., JR. 22 ACT OPH
2754 NORTH DECATUR RD #115, DECATUR 30030
BELL, CHARLES B. 22 ACT IM
465 WINN WAY STE 150, DECATUR 30030
BENNETT, GARLAND P., JR. 22 ACT FP
755 COLUMBIA DR STE 333, DECATUR 30030
BENNETT, WILLIAM J. 22 ACT IM
1462 MONTREAL RD STE 214, TUCKER 30084
BIELING, FRIEDRICH C. 22 ACT OBG
5040 SNAPFINGER WOODS DR, DECATUR 30035
BLACKSTON, RONALD D. 22 ACT PD
1365 CLIFTON RD NE, ATLANTA 30322
BLAIR, H. DUANE 22 ACT GS
755 COLUMBIA DR STE 919, DECATUR 30030
BLUESTEIN, BARRY M. 22 ACT IM
755 COLUMBIA DR, DECATUR 30030
BLUMBERG, RICHARD W. 22 R PD
2419 WOODWARD WAY NW, ATLANTA 30305
BLUMENFELD, ALVIN 22 ACT OBG
495 WINN WAY STE B-110, DECATUR 30030
BOBO, W. EARL 22 ACT GS
465 WINN WAY STE 201, DECATUR 30030
BOHAN, GUNAR N. 22 ACT PH
440 WINN WAY, DECATUR 30030
BOTSTEIN, GARY R. 22 ACT IM
2712 NORTH DECATUR RD, DECATUR 30033
BOWCOCK, JAMES Z. 22 ACT P
755 COLUMBIA DR STE 418, DECATUR 30030
BRANAN, WILLIAM J., JR. 22 ACT PDA,AL
5040 SNAPFINGER WOODS DR, DECATUR 30035
BRANDAU, A. GORDON, JR. 22 ACT IM
LAVISTA PERIMETER OFC PK, TUCKER 30084
BRANNON, LAWRENCE T. 22 ACT P
4928 LAVISTA RD, TUCKER 30084
BRICE, ANTON, JR. 22 ACT IM
495 WINN WAY STE B-220, DECATUR 30030
BRICKMAN, STANLEY PERRY, DDS 22 AF OS
755 COLUMBIA DR STE A, DECATUR 30030
BROOKS, BETTY ANN 22 ACT OBG
465 WINN WAY STE 100, DECATUR 30030
BRYAN, H. DAVID 22 ACT OBG
2183 NORTHLAKE PKY STE 102, TUCKER 30084
BUCHANAN, L.C. 22 ACT GS
374 WEST PONCE DE LEON AVE, DECATUR 30030
BURLESON, JAMES W. 22 ACT AN
755 COLUMBIA DR STE 413, DECATUR 30030
BURNETT, STACY W. 22 ACT PD
2100 PARKLAKE DR NE STE 15, ATLANTA 30345
BUTTERWORTH, H. HARPER 22 ACT IM
DISABILITY DETERMINATION UN, DECATUR 30030
CARSON, J. DAVID 22 ACT EM
2701 NORTH DECATUR RD, DECATUR 30033
CARSPECKEN, H. HUTSON 22 ACT PS
500 IRVIN CT STE C-250, DECATUR 30030
CARTER, JOHN LEROY, JR. 22 ACT OBG
5 PERIMETER OFFICE PK, TUCKER 30084
CARTER, LEON, JR. 22 ACT FP
465 WINN WAY STE 231, DECATUR 30030
CARTER, STEPHEN L. 22 ACT
7660 COVINGTON HWY, LITHONIA 30058
CASTLE, JOHN R. 22 ACT OBG
235 EAST PONCE DE LEON, DECATUR 30030
CODINGTON, ARTHUR B. 22 ACT IM
542 CHURCH ST RM 232, DECATUR 30030
COFFSKY, JAY S. 22 ACT R
755 COLUMBIA DR STE 205, DECATUR 30030
COLLINS, WILLIAM T., JR. 22 ACT FP
1462 MONTREAL RD STE 212, TUCKER 30084
COLVIN, RICHARD S. 22 ACT R
1365 CLIFTON RD NE, ATLANTA 30322
CONESCU, PAUL V. 22 ACT ORS
487 WINN WAY STE 101, DECATUR 30030
COOLEY, SARAH F. 22 ACT PTH
3644-B CHAMBLEE TUCKER RD, CHAMBLEE 30341
COOPER, JERRY L. 22 ACT D
495 WINN WAY STE 230-B, DECATUR 30030
COPPAGE, WILLIAM M. 22 ACT AN
755 COLUMBIA DR STE 413, DECATUR 30030
COVERT, GEORGE K. 22 ACT GP
PO BOX 1445, STONE MOUNTAIN 30086
CRANK, R. PAUL, JR. 22 ACT IM
1462 MONTREAL RD STE 312, TUCKER 30084
CRANMAN, JERARD S. 22 ACT IM
1275 MCCONNELL DR, DECATUR 30033
CRISPIN, ROY H. 22 ACT TS
465 WINN WAY STE 211, DECATUR 30030
DALY, FRANK T., JR. 22 ACT R
755 COLUMBIA DR STE 205, DECATUR 30030
DAVIDSON, CHARLES W. 22 ACT IM
755 COLUMBIA DR STE 713, DECATUR 30030
DAVIES, ROBERT L. 22 ACT R
755 COLUMBIA DR STE 205, DECATUR 30030
DAVIS, DONALD C. 22 ACT IM
1365 CLIFTON RD NE, ATLANTA 30322
DAVIS, MARK S. 22 ACT OBG
755 COLUMBIA DR STE 702, DECATUR 30030
DE BRA, DON W., JR. 22 ACT END
2712 NORTH DECATUR RD, DECATUR 30033
DEATON, BURRELL H. 22 ACT D
4303 LAVISTA RD, TUCKER 30084
DILLON, ROBERT G. 22 ACT IM
2054-B LAWRENCEVILLE HWY, DECATUR 30033
DISANTIS, DENNIS E. 22 ACT GE
487 WINN WAY STE 206, DECATUR 30030
DOUGLAS, JOHN S., JR. 22 ACT CD
1365 CLIFTON RD, ATLANTA 30322
DRESSLER, MARION S. 22 ACT P
785 HOUSTON MILL RD NE APT 2, ATLANTA 30329
DULL, MARTHA KATHERINE 22 ACT OBG
2831 NORTHLAKE PKY STE 102, TUCKER 30084
EARLEY, WILLIAM H. 22 ACT P
1935 CLIFF VALLEY WAY ' 110, ATLANTA 30329
EAVES, ROBERT F., JR. 22 ACT FP
2390 MAIN ST, TUCKER 30084
EDELSON, STEPHEN B. 22 ACT FP
5536-A FLAT SHOALS RD, DECATUR 30034
EIDEX, MARSHALL F. 22 ACT IM
487 WINN WAY STE 202, DECATUR 30030
EIDEX, MAXWELL A. 22 ACT IM
487 WINN WAY STE 202, DECATUR 30030

ELLZEY, B. FRANK 22 ACT OBG
1462 MONTREAL RD STE 107, TUCKER 30084
ELLZEY, JANE L. 22 ACT PD
5040 SNAPFINGER WOODS DR, DECATUR 30035
ERICKSON, WILLIAM G. 22 ACT GP
1745 OLD SPRINGHOUSE LN, DUNWOODY 30338
FEINGOLD, ALAN O. 22 ACT IM
755 COLUMBIA DR STE 618, DECATUR 30030
FELLNER, OONALD W. 22 ACT ORS
487 WINN WAY STE 101, DECATUR 30030
FERN, DAVID R. 22 ACT GS
500 IRVIN CT STE C-210, DECATUR 30030
FILARDI, GERALD A. 22 ACT U
755 COLUMBIA DR STE B, DECATUR 30030
FINE, ROBERT M. 22 ACT D,DMP
487 WINN WAY STE 209, DECATUR 30030
FITE, J. DONALD 22 ACT OPH
PO BOX 1798, DECATUR 30030
FLEMING, SIDNEY H. 22 ACT P
2238 HILL PARK CT, DECATUR 30033
FOKES, ERNEST C. 22 ACT NS
370 WINN WAY #201, DECATUR 30030
FOSTER, H.R. 22 ACT PD,PDC
7660 COVINGTON HWY, LITHONIA 30058
FREEMAN, LAWRENCE L. 22 ACT FP
3652 CHAMBLEE-DUNWOODY RD, CHAMBLEE 30341
FREGOSI, ALBERT H. 22 ACT U
2977 WILSONS CROSSING CT 'B, DECATUR 30033
FRIED, DENNIS A. 22 ACT CRS
558 MEDLOCK RD, DECATUR 30030
FUERST, JULIAN F. 22 ACT OBG
755 COLUMBIA DR STE 702, DECATUR 30030
GALLER, EOWIN J. 22 ACT IM
2054-R LAWRENCEVILLE HWY, DECATUR 30033
GAMMON, JAMES A. 22 ACT OPH
1365 CLIFTON RD, ATLANTA 30322
GANN, JOYCE A. 22 ACT OBG
465 WINN WAY STE 100, DECATUR 30030
GIBBS, R.I., JR. 22 ACT IM
2193 NORTH DECATUR RD, DECATUR 30033
GILBERT, CHARLES A. 22 ACT IM
1462 MONTREAL RD STE 218, TUCKER 30084
GOLLOBIN, GLENN S. 22 I&R
1075-B NORTH JAMESTOWN RD, DECATUR 30033
GONZALEZ, VICTOR R. 22 ACT P
1970 CLIFF VALLEY WAY NE, ATLANTA 30329
GOTLIEB, EDWARO 22 ACT ADL
5565-D MEMORIAL DR, STONE MOUNTAIN 30083
GOTLIEB, JAQUELIN 22 ACT PD
5565-D MEMORIAL DR, STONE MOUNTAIN 30083
GOTTLIEB, GEORGE R. 22 ACT A
365 WINN WAY STE 120, DECATUR 30030
GRANT, R. PEERY 22 ACT PYA,P
1493 LAVISTA RD NE, ATLANTA 30324
GRAY, SAMUEL H. 22 ACT GS
4555 NORTH SHALLOWFORD RD, ATLANTA 30338
GRIFFIN, JOHN B., JR. 22 ACT P
1711-B UPPERGATE DR NE, ATLANTA 30307
GUY, ERNEST P. 22 ACT AN
755 COLUMBIA DR STE 413, DECATUR 30030
HAAS, JOSEPH A. 22 ACT U
500 IRVIN CT STE C-230, DECATUR 30030
HALKOS, ALEXANOER A. 22 ACT IM
755 COLUMBIA DR STE 912, DECATUR 30030
HAROCASTLE, WILLIAM R. 22 ACT GS
487 WINN WAY STE 103, DECATUR 30030
HARDEN, TIMOTHY, JR. 22 ACT IM
711 CHURCH ST, DECATUR 30030
HARDY, WALLACE E. 22 ACT OBG
5 LAVISTA PERIMETER OFC PK, TUCKER 30084
HARGREAVES, HILARY K. 22 ACT PTH
DEKALB GENERAL HOSPITAL, ATLANTA 30033
HARREL, JOHN A., JR. 22 ACT PH
2701 NORTH DECATUR RD, DECATUR 30033
HARRIS, T.A. 22 ACT OBG
5040 SNAPFINGER WOODS DR, DECATUR 30035
HARRISON, JOHN R. 22 ACT FP
5372 PEACHTREE RD, CHAMBLEE 30341
HARTMAN, SANFORD S. 22 ACT RHU
2754 N DECATUR RD STE 111, DECATUR 30033
HARTMAN, TED E. 22 ACT FP
5040 SNAPFINGER WOODS DR, DECATUR 30032
HASSINGER, JOHN T. 22 ACT GS
497 WINN WAY STE A-130, DECATUR 30030
HEARD, JOHN P. 22 ACT FP
755 COLUMBIA DR STE 333, DECATUR 30030
HOOSE, KENNETH A., JR. 22 ACT IM
495 WINN WAY 'B-260, DECATUR 30030
HUBBELL, ROBERT W. 22 ACT IM
2193 NORTH DECATUR RD, DECATUR 30033
HUDGINS, WILLIAM B. 22 ACT IM
500 IRVIN CT STE C-240, DECATUR 30030
HUFF, PRENTIS B. 22 ACT ORS
755 COLUMBIA DR STE 825, DECATUR 30030
HUTCHINSON, WILLIAM L., JR. 22 ACT OBG
5040 SNAPFINGER WOODS DR, DECATUR 30035
INGRAM, CHARLES T. 22 ACT AN
2673 SHETLAND DR, DECATUR 30033
JACOBS, NORMAN FREDERICK, JR. 22 ACT IM,ID
2712 NORTH DECATUR RD, DECATUR 30033
JANN, WILLIAM K., JR. 22 ACT PD
1901 CENTURY BLVD STE 20, ATLANTA 30345
JANTER, THOMAS B. 22 ACT PD
4536 CHAMBLEE-DUNWOODY RD, ATLANTA 30338
JAROINA, PHILIP M. 22 ACT IM
711 CHURCH ST, DECATUR 30030
JOHNSON, EDWARD L. 22 ACT ORS
2910 NORTH DRUID HILLS RD, ATLANTA 30329
JOHNSON, LEWIS O. 22 ACT IM
4303 LAVISTA RD, TUCKER 30084
JOINER, JAMES C., III 22 ACT OPH
487 WINN WAY STE 201, DECATUR 30030
JONES, FOREST D. 22 ACT PD
1901 CENTURY BLVD STE 20, ATLANTA 30345
JONES, GEORGE R. 22 ACT FP
1462 MONTREAL RD STE 318, TUCKER 30084
JONES, JONSEY J. 22 I&R AN
4005 GRANTLAND DR, TUCKER 30084
JOVE, JULIO 22 ACT ORS
487 WINN WAY STE 108, DECATUR 30030
KANN, HERBERT E., JR. 22 ACT IM
500 IRVIN CT STE C-220, DECATUR 30030
KAPLAN, HENRY J. 22 ACT OPH
1365 CLIFTON RD NE, ATLANTA 30322
KEETON, WILLIAM F. 22 ACT AN
755 COLUMBIA DR STE 413, DECATUR 30030
KERLEY, CLIFFORD M. 22 ACT R
755 COLUMBIA DR STE 205, DECATUR 30030
KERR, WILLIAM K. 22 R FP
1555 SOUTH JOHNSON FERRY RD, ATLANTA 30319
KINLAW, WILLIAM K., JR. 22 ACT NS
370 WINN WAY STE 201, DECATUR 30030
KIRKLANO, ROBERT A., JR. 22 ACT IM
1510 OAK GROVE RD STE 1, DECATUR 30033
KNIGHT, EVELYN A. 22 ACT EM
PO BOX 8540, ATLANTA 30312
KRAMER, JOHN H. 22 ACT OPH
4553 NORTH SHALLOWFORD RD, ATLANTA 30338
KRONE, HOWARD B. 22 ACT ORS
484 IRVIN CT #220, DECATUR 30030
KULKIN, JAY 22 ACT OBG
5365 FIVE FORKS TRICKUM, LILBURN 30247
LASKEY, GARY M. 22 ACT R
755 COLUMBIA DR STE 205, DECATUR 30030
LASSITER, NOLAN M. 22 ACT IM
1276 MCCONNELL DR, DECATUR 30033
LAWVER, ALICE I. 22 ACT N
495 WINN WAY STE 150, DECATUR 30030
LEE, HOWARD B. 22 ACT FP
603 CHURCH ST, DECATUR 30030
LEEB, DIANNE CHERYL 22 ACT PS
1462 MONTREAL RD STE 411, TUCKER 30084
LEFF, PETER B. 22 ACT GE
487 WINN WAY STE 206, DECATUR 30030
LEFF, STEPHEN P. 22 ACT OPH
755 COLUMBIA DR STE 215, DECATUR 30030
LEONARD, ROBERT P. 22 ACT PS
500 IRVIN CT STE C-250, DECATUR 30030
LESLIE, JOHN T. 22 R PH
19 WILTSHIRE DR, AVONDALE ESTATES 30002
LEVENSON, DAVID S. 22 ACT OPH
2754 NORTH DECATUR RD, DECATUR 30033
LEVINE, KEITH A. 22 ACT OS
2754 NORTH DECATUR RD #104, DECATUR 30030
LEVINE, RAPHAEL S. 22 ACT IM
487 WINN WAY STE 105, DECATUR 30030
LEXOW, STEPHEN S. 22 ACT N
370 WINN WAY STE 103, DECATUR 30030
LITTON, JAMES H. 22 ACT FP
4173 FIRST AVE, TUCKER 30084
LUCKETT, JAMES M. 22 ACT R
2701 NORTH DECATUR RD, DECATUR 30033
LUCKEY, TOM M. 22 ACT IM
711 CHURCH ST, DECATUR 30030
LYNN, KAY F. 22 ACT OBG
5040 SNAPFINGER WOODS DR, DECATUR 30035
MAOELEY, JAMES B. 22 ACT ORS
1462 MONTREAL RD STE 114, TUCKER 30084
MAHON, THOMAS M. 22 ACT PD
4112 E PONCE DE LEON AVE, CLARKSTON 30021
MALLOY, TYRONE C. 22 ACT OBG
2853 CANDLER RD STE 4, DECATUR 30034
MANFREDI, JOHN A. 22 ACT ON
2054-E LAWRENCEVILLE HWY, DECATUR 30033
MANSFIELD, DONALD L. 22 ACT OBG
484 IRVIN CT STE 230, DECATUR 30030
MASON, JAMES L. 22 ACT P
1365 CLIFTON RD NE, ATLANTA 30322
MATHEWS, W. STANLEY 22 ACT PD
2100 PARK LAKE DR NE STE 15, ATLANTA 30345
MATTHEWS, LAWRENCE P. 22 ACT OBG
1357 OXFORD RD NE, ATLANTA 30307
MATTHEWS, W. FRANK 22 ACT PTH
2701 NORTH DECATUR RD, DECATUR 30033
MATTISON, RICHARO C. 22 ACT PS
993 JOHNSON FERRY RD NE, ATLANTA 30342
MAXEY, CLARENCE O. 22 ACT AN
755 COLUMBIA DR STE 413, DECATUR 30030
MCANULTY, MARTHA J. 22 ACT P
3081 MAPLE DR NE, ATLANTA 30305
MCCAIN, ARTHUR H. 22 I&R R
719 WEST PONCE DE LEON AVE, DECATUR 30030
MCCORMICK, GLENN E., JR. 22 ACT D
755 COLUMBIA DR STE 806, DECATUR 30030
MCCUISTON, C.F. 22 ACT IM
3610 CHAMBLEE-TUCKER RD, CHAMBLEE 30341
MCDOWELL, CHARLES W., JR. 22 ACT OPH
PO BOX 1798, DECATUR 30030
MCGINNIS, LAMAR S., JR. 22 ACT GS
365 WINN WAY STE 201, DECATUR 30030
MCLANE, JOHN E. 22 ACT OBG
365 WINN WAY STE 251, DECATUR 30030
MERSEREAU, JOHN B. 22 ACT EM,FP
560 LADONNA DR, DECATUR 30032
MEYER, ROGER A. 22 ACT MFS
1462 CLIFTON RD NE RM 214, ATLANTA 30345
MINOR, B. DONALO 22 ACT R,NR
2256 SAGAMORE HILLS DR, DECATUR 30033
MONETT, ROBERT A. 22 ACT FP
755 COLUMBIA DR STE 602, DECATUR 30030
MOON, ELLIOTT C. 22 ACT OBG
5 LAVISTA PERIMETER OFC PK, TUCKER 30084
MORGAN, DAVID L. 22 ACT PD
1901 CENTURY BLVD NE STE 20, ATLANTA 30345
MORGAN, FRANK E., JR. 22 ACT R
755 COLUMBIA DR STE 205, DECATUR 30030
MORGAN, Z.V., JR. 22 ACT IM
495 WINN WAY 'B-220, DECATUR 30030

MORLEY, ANDY P., JR. 22 ACT FP
755 COLUMBIA DR STE 333, DECATUR 30030

MORSE, CHESTER W. 22 ACT IM
711 CHURCH ST, DECATUR 30030

MOUSSAKHANI, JOSEPH 22 ACT OBG
497 WINN WAY STE A-115, DECATUR 30030

NADAL, GUILLERMO 22 ACT AN
755 COLUMBIA DR STE 413, DECATUR 30030

NAIB, Z.M. 22 ACT PTH
69 BUTLER ST SE, ATLANTA 30303

NAJJAR, OMAR A. 22 ACT FP
755 COLUMBIA DR STE 333, DECATUR 30030

NARDELLI-OLKOWSKA, KRYSTYNA 22 ACT
2181 NORTHLAKE PKY, TUCKER 30084

NARDONE, AUGUST J. 22 R FP
99 BERKELEY RD, AVONDALE ESTATES 30002

NIX, EDWARD O. 22 ACT P
1989 WILLIAMSBURG DR 'A, DECATUR 30033

NIXON, DANIEL W. 22 ACT ON
1365 CLIFTON RD NE, ATLANTA 30322

NODAL, RONALDO R. 22 ACT OBG
7 LAVISTA PERIMETER OFC PK, TUCKER 30084

NORMAN, MICHAEL 22 ACT N
370 WINN WAY STE 102, DECATUR 30030

NYSEWANDER, RICHARD W. 22 ACT P
2754 N DECATUR RD STE 102, DECATUR 30030

OBRIEN, JOHN F. 22 ACT D
1276 MCCONNELL DR, DECATUR 30033

OKEL, BENJAMIN B. 22 ACT IM
2193 NORTH DECATUR RD, DECATUR 30033

OLKOWSKI, Z.L. 22 A R
1365 CLIFTON RD NE, ATLANTA 30322

PARKINSON, ALEXANDER T. 22 ACT PTH
450 NORTH CANDLER ST, DECATUR 30030

PARSONS, RICHARD C. 22 ACT OTO
755 COLUMBIA DR STE 720, DECATUR 30030

PELTZ, ROSEMONDE S. 22 ACT IM
2054-P LAWRENCEVILLE HWY, DECATUR 30033

PERKINS, JACK B. 22 ACT AN
755 COLUMBIA DR STE 413, DECATUR 30030

PIHL, B. ALFRED 22 ACT PS
1462 MONTREAL RD STE 411, TUCKER 30084

PIRKLE, QUENTIN, SR. 22 ACT FP
BOX 10007, ATLANTA 30319

POMERANCE, ALAN J. 22 ACT OBG
1462 MONTREAL RD STE 412, TUCKER 30084

PORTER, MAC W. 22 ACT FP,OM
2100 PARKLAKE DR NE, ATLANTA 30345

POWELL, F.C. 22 ACT IM
200 SWANTON WAY STE 300, DECATUR 30030

POWELL, RALPH W. 22 ACT ON
1365 CLIFTON RD NE, ATLANTA 30322

PRATER, R. BURT, JR. 22 ACT FP
4553 NORTH SHALLOWFORD RD, ATLANTA 30338

PRINCE, RUSSELL B. 22 ACT P
1970 CLIFF VALLEY WAY NE, ATLANTA 30329

PRINTZ, DON W. 22 ACT D
4303 LAVISTA RD, TUCKER 30084

PRUETT, JAMES E. 22 ACT OTO
465 WINN WAY STE 221, DECATUR 30030

RAAEN, TOM D. 22 ACT PTH
2701 NORTH DECATUR RD, DECATUR 30033

RANDALL, R. BEAUVAIS, JR. 22 ACT IM
1275 MCCONNELL DR, DECATUR 30033

RAUBER, ALBERT PAUL 22 ACT PD
BOX 459, ATLANTA 30322

RAUSHER, DAVID B. 22 ACT IM,GE
1292 VISTA LEAF DR, DECATUR 30033

RAWLS, WILLIAM J. 22 ACT IM
755 COLUMBIA DR STE 912, DECATUR 30030

RAY, WALKER L. 22 ACT PD
4112 E PONCE DE LEON AVE, CLARKSTON 30021

REAGAN, RONALD C. 22 I&R GS
300 BOULEVARD NE, ATLANTA 30312

REICH, ROBERT A. 22 ACT IM
755 COLUMBIA DR STE 905, DECATUR 30030

REICHERT, WILLIAM W. 22 ACT PUD
495 WINN WAY STE B-260, DECATUR 30030

REMIGAILO, RICHARD V. 22 ACT U
1462 MONTREAL RD #418, TUCKER 30084

RHAME, MARLAN LEVAN 22 ACT P
497 WINN WAY #110-A, DECATUR 30030

RICE, M. HOBSON 22 ACT OPH
PO BOX 1798, DECATUR 30030

RICHIN, PAUL F. 22 ACT ORS
497 WINN WAY, DECATUR 30030

RIESENBERG, ROBERT A. 22 ACT P
2754 N DECATUR RD STE 102, DECATUR 30030

ROGERS, J.V., JR. 22 ACT R
1365 CLIFTON RD, ATLANTA 30322

ROGERS, PHILLIP R. 22 ACT FP
4553 NORTH SHALLOWFORD RD, ATLANTA 30338

ROJAS, ORLANDO O. 22 ACT
9 CORPORATE SQ NE STE 110, ATLANTA 30329

ROSEN, RONALD M. 22 ACT CHP
1935 CLIFF VALLEY WAY NE, ATLANTA 30329

ROSENBAUM, BARRY J. 22 ACT NEP
497 WINN WAY NE STE A-210, DECATUR 30030

ROSENFELD, JOSEPH M. 22 ACT PD
5008 SNAPFINGER WOODS DR, DECATUR 30035

ROUNTREE, CLYDE B. 22 ACT P
755 COLUMBIA DR STE 418, DECATUR 30030

ROWELL, ROGER R. 22 ACT OPH
PO BOX 1798, DECATUR 30030

ROWLAND, DAVID M. 22 ACT U
755 COLUMBIA DR STE 520, DECATUR 30030

SAFRA, MARK J. 22 ACT OPH
1276 MCCONNELL DR, DECATUR 30033

SANDERS, FLOYD R., JR. 22 ACT FP
603 CHURCH ST, DECATUR 30030

SCHNEIDERMAN, STEVEN M. 22 ACT IM
2712 NORTH DECATUR RD, DECATUR 30033

SCHREEDER, JOHN M. 22 R FP
4165 CHAMBLEE-DUNWOODY RD, CHAMBLEE 30341

SEESE, PERRY G. 22 ACT P
1970 CLIFF VALLEY WAY ' 218, ATLANTA 30329

SESSIONS, GEORGE P. 22 ACT AN
755 COLUMBIA DR STE 413, DECATUR 30030

SHARON, ZEEV 22 ACT IM,NEP
497 WINN WAY STE A-210, DECATUR 30030

SHERMAN, STANLEY WILLIAM 22 ACT IM
495 WINN WAY STE B-260, DECATUR 30030

SHETTY, YESHWANTHI 22 ACT P
2531 BRIARCLIFF RD #211, ATLANTA 30329

SIEGEL, DONALD 22 ACT GS
755 COLUMBIA DR STE 717, DECATUR 30030

SILFEN, SHERYL L. 22 ACT OBG
465 WINN WAY STE 100, DECATUR 30030

SILVERMAN, STUART H. 22 ACT OPH
5040 SNAPFINGER WOODS DR, DECATUR 30035

SIMMONS, JOHN W., III 22 ACT PD
4112 E PONCE DE LEON AVE, CLARKSTON 30021

SKELTON, W. DOUGLAS 22 ACT P
PO BOX AF, ATLANTA 30322

SMITH, DOUGLAS 22 ACT ORS
1405 CHURCH ST, DECATUR 30030

SMITH, WILLIAM P., JR. 22 ACT IM
4231 REDAN RD, STONE MOUNTAIN 30083

SPRUELL, WILLIAM H. 22 ACT RHU
2712 NORTH DECATUR RD, DECATUR 30033

STATHAM, GEORGE W. 22 ACT PD
4112 E PONCE DE LEON AVE, CLARKSTON 30021

STATON, JEAN STEWART 22 ACT IM
2754 N DECATUR RD STE 112, DECATUR 30033

STEPHENSON, ROBERT E., III 22 ACT DR
755 COLUMBIA DR STE 205, DECATUR 30030

STEVES, ELMA M. 22 ACT PD
3624 CHAMBLEE-TUCKER RD, CHAMBLEE 30341

STOVALL, RUSSELL H., JR. 22 ACT OTO
484 IRVIN CT STE 140, DECATUR 30030

STROM, CARL H. 22 ACT FP
5040 SNAPFINGER WOODS DR, DECATUR 30035

STUBBS, D. WYTCH, JR. 22 ACT FP
1462 MONTREAL RD #303, TUCKER 30084

STUCKEY, KATHERINE 22 ACT AN
727 KENILWORTH CIR, STONE MOUNTAIN 30083

SYN, WAI YUN 22 ACT IM
1462 MONTREAL RD, TUCKER 30084

SYRIBEYS, JOHN P. 22 ACT GS
3576-A CHAMBLEE-TUCKER RD, CHAMBLEE 30341

TABATABAI, JAFAR 22 ACT FP
1039 THIRD ST, STONE MOUNTAIN 30083

TALBOTT, G. DOUGLAS 22 ACT IM
3985 SOUTH COBB DR STE 210, SMYRNA 30080

TALLEY, JOEL D., III 22 I&R IM
1750-13 CLAIRMONT RD, DECATUR 30033

TAPIA, RENE A. 22 ACT PTH
2701 NORTH DECATUR RD, DECATUR 30033

TATUM, JOSEPH C. 22 ACT ORS
1405 CHURCH ST, DECATUR 30030

TAYLOR, JOHN EDWIN, JR. 22 ACT PD
4112 E PONCE DE LEON AVE, CLARKSTON 30021

TEATE, H. LUTEN, JR. 22 ACT PD
1901 CENTURY BLVD NE #20, ATLANTA 30345

TEUTSCH, CAROL B. 22 ACT END
484 IRVIN CT STE 240, DECATUR 30030

TIDWELL, THOMAS J. 22 ACT R,ON
2701 NORTH DECATUR RD, DECATUR 30033

TILLMAN, RALPH A. 22 ACT OBG
5040 SNAPFINGER WOODS DR, DECATUR 30035

TINDALL, GEORGE T. 22 ACT NS
1365 CLIFTON RD, ATLANTA 30322

TINDALL, SUZIE C. 22 ACT NS
80 BUTLER ST SE, ATLANTA 30303

TIPPINS, WILLIAM C., JR. 22 ACT OBG
5040 SNAPFINGER WOODS DR, DECATUR 30035

TORRANCE, CLARENCE B. 22 ACT PD
4536 CHAMBLEE-DUNWOODY RD, ATLANTA 30338

TORRES, WILLIAM E. 22 ACT R
1365 CLIFTON RD NE, ATLANTA 30322

TRACHT, ARTHUR L. 22 ACT ORS
497 WINN WAY STE A-260, DECATUR 30030

TROTTER, JOHN F. 22 ACT FP
484 IRVIN CT STE 110, DECATUR 30030

TUGGLE, M. VIRGINIA 22 ACT IM
1336 COLUMBIA DR, DECATUR 30032

TURNER, DANIEL R. 22 ACT IM
755 COLUMBIA DR STE 618, DECATUR 30030

TURNER, DON W. 22 ACT P
2905 PEACHTREE RD NE, ATLANTA 30305

TURNER, H. LEONARD, JR 22 ACT IM
1275 MCCONNELL DR, DECATUR 30033

VANDERYT, WILLIAM J. 22 ACT ORS
1462 MONTREAL RD STE 114, TUCKER 30084

VANDIVER, ROY W. 22 ACT NS
370 WINN WAY STE 201, DECATUR 30030

VERRAS, ATHANASIOS 22 ACT PD
2100 PARKLAKE DR NE, ATLANTA 30345

VINSON, T.O. 22 R PH
1480 RAINIER FALLS DR NE, ATLANTA 30329

VOGLER, WILLIAM R. 22 ACT HEM
1365 CLIFTON RD, ATLANTA 30322

WADE, ROBERT C. 22 R FP
798 RAYS RD, STONE MOUNTAIN 30083

WALDEN, CHARLES W. 22 ACT P
1462 MONTREAL RD STE 216, TUCKER 30084

WALKER, JAMES A. 22 ACT U
755 COLUMBIA DR 'B, DECATUR 30030

WALKER, JEROME M., JR. 22 ACT N
370 WINN WAY STE 101, DECATUR 30030

WALKER, JOHN W. 22 ACT OBG
465 WINN WAY STE 150, DECATUR 30030

WALKER, KNOX, JR. 22 ACT ORS
PO BOX 1517, DECATUR 30030

WALKER, MARY E. 22 R PD
RTE 7 HOLLAND RD, CUMMING 30130

WALKER, W.W., III 22 ACT OBG
365 WINN WAY STE 140, DECATUR 30030

WALLACE, RUSSELL W., JR. 22 ACT N
370 WINN WAY STE 104, DECATUR 30030
WALZ, PETER D. 22 ACT IM
2054-B LAWRENCEVILLE HWY, DECATUR 30033
WARD, CHARLES J. 22 ACT OBG
365 WINN WAY STE 140, DECATUR 30030
WARD, RICHARD S. 22 ACT P
1711 UPPERGATE DR NE, ATLANTA 30307
WARING, GEORGE O. 22 ACT OPH
1365 CLIFTON RD NE, ATLANTA 30322
WATKINS, CHARLES B. 22 ACT FP
3652 CHAMBLEE-DUNWOODY RD, CHAMBLEE 30341
WEIDENHEIM, KAREN M. 22 I&R PTH
EMORY UNIVERSITY, ATLANTA 30322
WHITAKER, WILLIAM G., III 22 ACT DR
755 COLUMBIA DR STE 205, DECATUR 30030
WHITSON, THEODORE C. 22 ACT PS
365 WINN WAY STE 241, DECATUR 30030
WILLIAMS, ROBERT A. 22 ACT OM
1034 WINDING RIDGE CT, DUNWOODY 30338
WILLS, S. ANGIER 22 ACT ON
755 COLUMBIA DR STE 613, DECATUR 30030
WILSON, HENRY H. 22 ACT PD
1510 OAK GROVE RD STE 6, DECATUR 30033
WYLIE, JAMES E. 22 ACT OBG
1275-A MCCONNELL DR, DECATUR 30033
YU, CHENG LING 22 ACT OBG
365 WINN WAY STE 100, DECATUR 30030
ZWEIG, ARNOLD 22 ACT OTO
3644-C CHAMBLEE-TUCKER RD, ATLANTA 30341
ZWIREN, GERALD T. 22 ACT PDS
1901 CENTURY BLVD NE, ATLANTA 30345

23—DOUGHERTY

ADAMS, WILLIE, JR. 23 ACT OBG
320 SECOND AVE, ALBANY 31701
ALLEN, ARTHUR T. 23 ACT AN
911 FIFTH AVE, ALBANY 31701
ALLEN, EDWIN W., III 23 ACT EM
PO BOX 1828, ALBANY 31703
ANDREWS, JOHN RONALD 23 ACT R
PO BOX 1924, ALBANY 31703
ARMSTRONG, EDWARD S. 23 ACT IM
1603 WEST THIRD AVE, ALBANY 31707
BAKER, JOHN B. 23 ACT N
500 THIRD AVE #102, ALBANY 31701
BATEMAN, J. OAN 23 ACT GS
PO BOX 1170, ALBANY 31702
BERG, JOSEPH L. 23 ACT OPH
PO BOX 483, ALBANY 31702
BOWMAN, M.B. 23 ACT GS
RTE 3 BOX 594-M, ALBANY 31707
BOYD, DONALO L. 23 ACT ORS
1105 PALMYRA RD, ALBANY 31708
BOYETTE, D. MORTON 23 ACT OTO
804 14TH AVE, ALBANY 31708
BRIDGER, CLARENCE E. 23 ACT PTH
PO BOX 1828, ALBANY 31702
BRIDGES, WILLIAM H. 23 R R
4501 OLD DAWSON RD, ALBANY 31707
BROCK, WILLIAM A. 23 ACT IM
1700 EAST BROAD AVE, ALBANY 31705
BROWNSTEIN, RICHARD E. 23 ACT IM,GE
806 14TH AVE, ALBANY 31701
BUCKNER, LESLIE 23 ACT OBG
RTE 3 BOX 446, LEESBURG 31763
BUNTIN, WILLIAM H. 23 ACT AN
2503 PHEASANT DR, ALBANY 31707
BURNETT, OMER L., JR. 23 ACT R
PO BOX 1924, ALBANY 31703
CALHOUN, A. DOUGLAS 23 ACT GS
801 - 13TH AVE, ALBANY 31701
CALHOUN, CLARENCE 23 ACT GS
PO BOX 2031, ALBANY 31702
CARGILL, LOUIS H. 23 ACT GP
1009 NORTH MONROE STE 102, ALBANY 31701
CARROLL, ROBERT R. 23 ACT IM,HEM
500 THIRD AVE STE 109, ALBANY 31701
CARTER, DAVID K. 23 ACT EM
PO BOX 1828, ALBANY 31703
CARTER, OTHA B., JR. 23 ACT GS
801 - 13TH AVE, ALBANY 31701
CHASTAIN, GEORGE M. 23 ACT AN
2614 RIDGEWOOD LN, ALBANY 31707
CHOI, USUP 23 ACT ORS
1909 ABERDEEN RD, ALBANY 31701
CLARK, EUGENE 23 ACT NEP
507 THIRD AVE, ALBANY 31701
COATES, GRAHAM 23 ACT P
1112 NORTH MADISON, ALBANY 31705
COLEMAN, WILLIAM M. 23 ACT ORS
1136 DAWSON RD, ALBANY 31707
COLLINS, CHAPPELL A., JR. 23 ACT FP
810 13TH AVE, ALBANY 31701
CORR, J. PRICE, JR. 23 ACT GS
806 14TH AVE, ALBANY 31701
CRIMMINS, L.T. 23 ACT GS
1111 PALMYRA RD, ALBANY 31701
DAVIS, LEO J. 23 ACT OTO
804 14TH AVE, ALBANY 31708
DICKINSON, RICHARD F. 23 R R
407 BAY SHORE, PANAMA CITY FL 32407
DIXON, A.V., JR. 23 ACT CHP
514 FOURTH AVE, ALBANY 31701
DIXON, JOHN M. 23 ACT OPH
1909 ABERDEEN RD STE 108, ALBANY 31701
OORSEY, HARRY N. 23 ACT IM
PO BOX 288, ALBANY 31702
ERHARDT, WALTER L., JR. 23 ACT PS
507 THIRD AVE, ALBANY 31701
FANG, KUO-KANG 23 ACT IM
507 THIRD AVE STE 3, ALBANY 31701
FINNEY, C.E. 23 R OPH
RT 4 BOX 73, LEESBURG 31763
FLOURNOY, EOWIN E., JR. 23 ACT FP
810-13TH AVE, ALBANY 31701
FOUNTAIN, T. GRAY 23 ACT GS
910 NORTH JEFFERSON, ALBANY 31708
FOWLER, MARK W. 23 ACT FP
1010 NORTH MADISON ST, ALBANY 31701
FREEMAN, ATWOOO M., JR. 23 ACT ORS
1105 PALMYRA RD, ALBANY 31708
FREEMAN, JAMES M. 23 ACT CDS
500 THIRD AVE, ALBANY 31701
GEORGE, WILLIAM M., JR. 23 ACT OBG
414 FIFTH AVE, ALBANY 31708
GILLESPIE, CHARLES B. 23 ACT ORS
810 14TH AVE, ALBANY 31708
GOLDSMITH, ABRAM O. 23 ACT OBG
PO BOX 714, ALBANY 31702
GORDON, WALTER C. 23 ACT GS
401-A SOUTH MADISON ST, ALBANY 31701
GRANT, JOHN R. 23 ACT OTO
804-14TH AVE, ALBANY 31708
GROVES, ROBERT H. 23 ACT FP
PO BOX 1908, ALBANY 31703
GUILLEBEAU, F. DEMPSEY 23 ACT IM
PO BOX 288, ALBANY 31702
HAKIM, FAEZ 23 ACT PTH
2206 WESTMORELAND DR, ALBANY 31707
HANCOCK, CARL V., JR. 23 ACT U
810-13TH AVE, ALBANY 31701
HARPER, WILLIAM F. 23 ACT GS
810 13TH AVE, ALBANY 31701
HATTAWAY, JAMES R. 23 ACT U
810 13TH AVE, ALBANY 31701
HILSMAN, THOMAS A. 23 ACT FP
PO BOX 1908, ALBANY 31701
HOLLIS, CHARLES D., JR. 23 ACT IM
1610 NORTH VALENCIA DR, ALBANY 31707
HOLMAN, C.M. 23 ACT GYN
412 FOURTH AVE, ALBANY 31705
HOOD, HERB L. 23 ACT AN
2335 WINCHESTER DR, ALBANY 31707
HOOPES, JEFFREY R. 23 ACT CD
PO BOX 1326, ALBANY 31702
HOTZ, JAMES A. 23 ACT IM
1700 EAST BROAD AVE, ALBANY 31705
HUBBARD, JAMES A. 23 ACT OBG
401-B SOUTH MADISON, ALBANY 31701
HUMPHRIES, CHARLIE, JR. 23 ACT OBG
401-B SOUTH MADISON ST, ALBANY 31701
INMAN, JOHN S., JR. 23 ACT OBG
414 FIFTH AVE, ALBANY 31701
ISELE, ANTHONY F. 23 ACT PTH
PO BOX 1908, ALBANY 31703
JOHNSON, THOMAS D. 23 ACT IM
PO BOX 288, ALBANY 31702
JOROAN, JOSEPH L. 23 ACT FP
504 COLLEGE DR, ALBANY 31705
KIM, TAE W. 23 ACT EM
1906 COVEY RD, ALBANY 31707
KLEMANN, GILBERT S. 23 ACT OBG
1001 NORTH MONROE, ALBANY 31701
KNOWLES, VAN CISE 23 ACT GS
PO BOX 2049, ALBANY 31701
KUO, MAX 23 ACT PD
810 - 13TH AVE, ALBANY 31701
KUSUMA, VITHAL 23 ACT IM
1009 NORTH MONROE ST STE 107, ALBANY 31701
LAMB, CHARLES C. 23 ACT FP
910 NORTH JEFFERSON, ALBANY 31701
LANE, W.K. 23 ACT U
810 13TH ST, ALBANY 31701
LARIOSA, OIOSITA W. 23 ACT PD
520 FOURTH AVE, ALBANY 31701
LASLIE, MICHAEL N. 23 ACT AN
2207 ASHFORD DR, ALBANY 31707
LEACH, WILLIAM WALLACE 23 ACT OBG
1001 NORTH MONROE, ALBANY 31701
LEE, WAI YEE 23 ACT PD
802 NORTH MONROE, ALBANY 31701
LOWERY, WILLIAM O., JR. 23 ACT NS
PO BOX 625, ALBANY 31702
MANNS, WILLIAM J. 23 ACT IM
1909 ABERDEEN STE 101, ALBANY 31701
MARSH, DUNCAN R. 23 ACT ORS
810 - 14TH AVE, ALBANY 31708
MARTIN, JAMES B. 23 ACT GYN
235 ROOSEVELT AVE STE 124, ALBANY 31701
MATTHEW, ROBERT A. 23 ACT AN
1625 LOWELL LN, ALBANY 31707
MAYHER, WILLIAM E., III 23 ACT NS
PO BOX 625, ALBANY 31702
MCCALL, CHARLES S., JR. 23 ACT IM
412 FOURTH AVE, ALBANY 31701
MCDANIEL, J.Z. 23 ACT U
1113 TENTH AVE, ALBANY 31707
MCKINNEY, RAY L. 23 ACT R
PO BOX 1924, ALBANY 31703
MCLENDON, REMBERT L. 23 ACT ORS
803 NORTH JEFFERSON ST, ALBANY 31701
MEIER, MARK C. 23 ACT EM
2615 WELLINGTON DR, ALBANY 31707
MENDENHALL, CHARLES M. 23 ACT R,TR
PO BOX 63, ALBANY 31702
MIDDLETON, FRANK F., III 23 ACT OBG
414 FIFTH AVE, ALBANY 31701
MITCHELL, C. CRAIG 23 ACT IM,CD
PO BOX 1326, ALBANY 31702
MOREE, LAMAR H. 23 ACT AN
2604 EAST DOUBLEGATE, ALBANY 31707
NEWTON, WALTER M., JR. 23 ACT PS
1909 ABERDEEN DR, ALBANY 31701
NIELSON, CRAIG M. 23 ACT PUD,IM
1100 NORTH MADISON ST, ALBANY 31701

OGLESBY, JAMES W. 23 ACT IM,EM
RTE 3 BOX 375-A, LEESBURG 31763
PAGE, CROCKETT H. 23 S GP
333 MOCK ROAD APT 101, ALBANY 31705
PARISH, HAVNER H., JR. 23 ACT U
802 NORTH JEFFERSON ST, ALBANY 31708
PARROTT, FRANK H. 23 ACT IM,PUD
806 FOURTEENTH AVE, ALBANY 31701
PASCHAL, J. DEAN 23 ACT PD
910 NORTH JEFFERSON ST, ALBANY 31701
PASCHAL, THOMAS C. 23 ACT PD
910 NORTH JEFFERSON ST, ALBANY 31701
POULOS, PHILLIP R. 23 ACT IM
1700 EAST BROAD AVE, ALBANY 31705
RAWLS, OTIS GREY 23 ACT GS
910 NORTH JEFFERSON, ALBANY 31708
RICHARDSON, A. CULLEN, III 23 ACT GS
801 - 13TH AVE, ALBANY 31701
RICHARDSON, R.C. 23 ACT OTO
400 FOURTH AVE, ALBANY 31701
ROBERSON, PHIL E. 23 ACT GS
PO BOX 343, ALBANY 31702
ROBERTS, MICHAEL H. 23 ACT CDS
500 THIRD AVE, ALBANY 31701
ROBERTS, PHILLIP L. 23 ACT IM,HEM
500 THIRD AVE STE 109, ALBANY 31701
SAFER, LESLIE F. 23 ACT D
426 SECOND AVE, ALBANY 31701
SAFLEY, BRENDA R. 23 ACT AN
2605 WEST DOUBLE GATE DR, ALBANY 31707
SAFLEY, WILLIAM L. 23 ACT TS
500 THIRD AVE, ALBANY 31701
SAMPAT, JAYSHREE H. 23 ACT DR
PO BOX 1924, ALBANY 31703
SANDERS, JOHN W. 23 ACT PD
412 FOURTH AVE, ALBANY 31701
SCHWARTZ, RONALD O. 23 ACT OBG
ALBANY TOWERS STE 316, ALBANY 31701
SCOGGINS, BERNARD P. 23 ACT IM
1700 EAST BROAD AVE, ALBANY 31705
SEYMOUR, GLENN E. 23 ACT GS
410 FOURTH AVE, ALBANY 31701
SMITH, BRUCE A. 23 ACT PD
419 FOURTH AVE, ALBANY 31701
SMITH, CHRISTOPHER CAMPBELL 23 I&R GS
500 MEADOWLARK DR, ALBANY 31707
STONE, JAMES H. 23 ACT FP
2202 EAST OGLTHORPE, ALBANY 31705
STRICKLAND, SAMUEL L. 23 ACT DR
PO BOX 1924, ALBANY 31703
STUBBS, JOSEPH W. 23 ACT IM
PO BOX 288, ALBANY 31703
SUTTON, JAMES MACK, JR. 23 ACT PD
412 FOURTH AVE, ALBANY 31701
SWEAT, MAXWELL J., JR. 23 ACT PD
2609 EAST DOUBLEGATE DR, ALBANY 31707
TALLEY, J. LECONTE, JR. 23 ACT OBG
901 NORTH MADISON ST, ALBANY 31705
THAMES, FRANK MAYNARD, JR. 23 ACT DR
PO BOX 1924, ALBANY 31703
THOMAS, FRANK E. 23 ACT PD
2419 EAST ALBERSON DR, ALBANY 31707
TONG, KUN YUAN 23 ACT OBG
420 FOURTH AVE, ALBANY 31701
TRULOCK, ALBERT S., JR. 23 ACT GS
800 NORTH JEFFERSON ST, ALBANY 31701
TURNER, DAVID A. 23 ACT P
PO BOX 1828, ALBANY 31703
WALKER, BEVERLY D. 23 ACT PD
311 SECOND AVE, ALBANY 31701
WALL, SCOT A. 23 ACT OPH
2308 PALMYRA RD, ALBANY 31701
WALLER, ROBERT D. 23 ACT R
PO BOX 1924, ALBANY 31703
WHITE, PAUL C., JR. 23 ACT PH
1109 NORTH JACKSON ST, ALBANY 31701
WHITTLE, MICHAEL R. 23 ACT PTH
2800 NORTH DOUBLE GATE RD, ALBANY 31707
WILLIAMS, THEODORE G. 23 ACT ORS
1105 PALMYRA RD, ALBANY 31708
WOOD, CLAYTON E. 23 ACT D
426 SECOND AVE, ALBANY 31701
WOODARD, OTIS J., JR. 23 ACT P
1304 WHISPERING PINES RD, ALBANY 31707
WOODS, JAMES D. 23 ACT OBG
320 SECOND AVE, ALBANY 31701
YALAMANCHILI, GANDHIJI 23 ACT IM,GE
1009 NORTH MONROE ST STE 107, ALBANY 31701

24—CAMDEN-CHARLTON

ALVAREZ, RAMON V. 24 ACT FP
PO DRAWER 170, ST MARYS 31558
BENNETT, HENRY A 24 AF US
709 WEST CONYERS ST, ST MARYS 31558
BOATWRIGHT, JERRY A. 24 ACT GP
DRAWER EEE, ST MARYS 31558
HARRISON, WILLIAM V. 24 ACT GP
100 PASSIEU CIR, FOLKSTON 31537
HILL, MEREDITH L., JR 24 AF US
BOX 187, KINGSLAND 31548
JACKSON, JOSEPH M. 24 ACT FP
BOX 578, FOLKSTON 31537
KEENE, WILLIS R. 24 ACT IM
1001 NORTH THIRD ST, FOLKSTON 31537
LEVY-ELICEIRI, CARLOS A. 24 ACT GS
905-A DILWORTH ST, ST MARYS 31558

25—EMANUEL

FROST, H.R. 25 R FP
EAST PINE ST, SWAINSBORO 30401
GUZMAN, GERARDO H. 25 ACT GP
BOX 729, SWAINSBORO 30401
KIM, CHANG 25 ACT R
PO BOX 783, SWAINSBORO 30401
MEADOWS, CARTER LEE 25 ACT GS
PO BOX 879, SWAINSBORO 30401
RAY, JAMES LEON 25 ACT FP
PO BOX 1330, SWAINSBORO 30401
SMITH, H.W. 25 ACT OBS
PO BOX 160, SWAINSBORO 30401

26—FLINT

ADAMS, JOHN B., JR. 26 ACT FP
408 EAST THIRD AVE, CORDELE 31015
BARR, ROBERT E. 26 ACT FP
408 EAST THIRD AVE, CORDELE 31015
BUSBEE, PERRY G. 26 ACT FP
PO BOX 587, CORDELE 31015
CHRISTMAS, JOSEPH T. 26 ACT FP
VIENNA 31092
COLEMAN, OTHA K. 26 ACT FP
115 WEST 13TH AVE, CORDELE 31015
DINOLOV, JORDAN V. 26 ACT FP
PO BOX 232, ASHBURN 31714
DUVALL, DAVID W. 26 ACT IM
PO BOX 1194, CORDELE 31015
GARRETT, ROBERT C. 26 ACT FP
PO BOX 427, VIENNA 31092
GOOLSBY, LOUIS WAYNE 26 I&R FP
110 EAST 13TH AVE, CORDELE 31015
GOSS, CHRISTOPHER C. 26 R FP
ASHBURN 31714
GOSS, WOODROW 26 ACT FP
345 EAST WASHINGTON ST, ASHBURN 31714
GREER, CHARLES C. 26 ACT OPH
1702 EAST 20TH AVE, CORDELE 31015
JENKINS, CHARLES A. 26 ACT IM
PO BOX 395, VIENNA 31092
PANNELL, WILLIAM P. 26 ACT GS
PO BOX 1016, CORDELE 31015
PIRKLE, T.N. 26 ACT R
212 GORDON ST UNIT 7, LA GRANGE 30240
REYNOLDS, JAMES WILEY 26 ACT FP
PO BOX 549, ASHBURN 31714
WAGNER, GEORGE C. 26 ACT IM
PO BOX 1194, CORDELE 31015

27—FLOYD-POLK-CHATTOOGA

ANDERSON, BENJAMIN S., JR. 27 ACT FP
PO BOX 508, CEDARTOWN 30125
ANDREWS, RUSSELL E. 27 ACT OBG
316 WEST TENTH ST STE A, ROME 30161
ARANDA, RICARDO J. 27 ACT OBG
320 WEST NINTH ST, ROME 30161
ATHA, JOHN F. 27 ACT FP
HOGUE AVE, ROCKMART 30153
ATHA, WILLIAM J., JR. 27 ACT
20 RIVERMONT DR SW, ROME 30161
BATTLE, LEE H., JR. 27 ACT GS
321 WEST SEVENTH ST, ROME 30163
BAYDAR, ISIK D. 27 ACT IM
508 NORTH MAIN ST, CEDARTOWN 30125
BELL, SIDNEY A. 27 ACT ORS
HARBIN CLINIC, ROME 30161
BOWEN, ALAN L. 27 ACT ORS
1825 MARTHA BERRY BLVD, ROME 30161
BRANNON, EMMETT S. 27 ACT IM
3 PROFESSIONAL CT, ROME 30161
BREWSTER, EDWARD W., JR. 27 ACT R
1104 MARTHA BERRY BLVD, ROME 30161
BRICE, BOYCE S. 27 ACT GS
HARBIN CLINIC, ROME 30161
BROCK, ROY CRAWFORD 27 ACT GS
14 PROFESSIONAL CT, ROME 30161
BURK, BILLY D. 27 ACT OBG
909 NORTH FIFTH AVE, ROME 30161
CATES, ROBERT M. 27 ACT OBG
10 HOSPITAL CIR, ROME 30161
CAUTHEN, LARRY R. 27 ACT AN
13 JOHN MADDOX DR, ROME 30161
COLLIER, M. DWAYNE 27 ACT U
321 TURNER MCCALL BLVD, ROME 30161
COLLINS, JOHN T. 27 ACT OBG
316 WEST TENTH ST, ROME 30161
CONNELL, H.R., JR. 27 ACT OPH
HARBIN CLINIC, ROME 30161
CORPE, R.F. 27 ACT GS
417 MOUNT ALTO RD, ROME 30161
CULBRETH, ERNEST W. 27 ACT FP
525 EAST 11TH ST, ROME 30161
CUMMINGS, T.E. 27 ACT FP
HOGUE AVE, ROCKMART 30153
DAVIDSON, GENE G. 27 ACT IM
7 JOHN MADDOX DR, ROME 30161
DAVIS, WILLIAM S. 27 ACT P
PO BOX 6206, ROME 30163
DAWSON, HARRY E., JR. 27 ACT PS
HARBIN CLINIC, ROME 30161
DELLINGER, RAIDEN W. 27 R GS
702 RIVER AVE, ROME 30161
DICKINSON, JOHN I. 27 ACT GS
310 WEST SIXTH ST, ROME 30161
DOHRMANN, DAVID M. 27 ACT PD
16 HOSPITAL CIR, ROME 30161
DOOLEY, WILLIAM D. 27 ACT R
PO BOX 2625, ROME 30161
EDGENS, JACK R. 27 ACT R
RTE 10, ROME 30161
ELLIOTT, C.B. 27 ACT GS
134 EAST FAIRMOUNT AVE, CEDARTOWN 30125

FARRELL, ROBERT A. 27 ACT PTH
FLOYD COUNTY HOSPITAL, ROME 30161
FERGUSON, JAMES P. 27 ACT NS
1825 MARTHA BERRY BLVD, ROME 30161
FLOWERS, THOMAS EDWARD 27 ACT OPH
103 JOHN MADDOX DR, ROME 30161
FORMBY, LARRY H. 27 ACT U
1013 NORTH FIFTH AVE, ROME 30161
GAFFORO, A.V. 27 R OPH
101 MAPLEWOOD DR, ROME 30161
GILBERT, PETER G. 27 ACT U
HARBIN CLINIC, ROME 30161
GILBERT, WARREN 27 ACT FP
HARBIN CLINIC, ROME 30161
GOLDIN, HAROLD W. 27 ACT FP
132 EAST ELM ST, ROCKMART 30153
GOOOWIN, H.A., JR. 27 ACT FP
PO BOX 429, SUMMERVILLE 30747
GRAY, A. RICHARD 27 ACT GS
310 WEST SIXTH ST, ROME 30161
GRUBBS, JOHN E. 27 ACT N
1825 MARTHA BERRY BLVD, ROME 30161
HANKS, JEFFERSON D., JR. 27 ACT R
1104 MARTHA BERRY BLVD, ROME 30161
HARBIN, BANNESTER L., JR. 27 ACT GS
HARBIN CLINIC, ROME 30161
HARBIN, BUFORO G. 27 ACT PUD
1825 MARTHA BERRY BLVD, ROME 30161
HARBIN, LESTER 27 ACT GS
HARBIN CLINIC, ROME 30161
HARBIN, R.M., JR. 27 ACT GS
814 EAST 2ND AVE #4, ROME 30161
HARBIN, ROBERT L. 27 ACT OPH
1825 MARTHA BERRY BLVD, ROME 30161
HARBIN, THOMAS S. 27 ACT OPH
HARBIN CLINIC, ROME 30161
HARBIN, W.P., JR. 27 ACT IM
HARBIN CLINIC, ROME 30161
HARBIN, WILLIAM P. 27 ACT R
1104 MARTHA BERRY BLVD, ROME 30161
HINES, ROBERT C. 27 ACT FP
HARBIN CLINIC, ROME 30161
HORTMAN, H.C. 27 ACT OBG
10 HOSPITAL CIR, ROME 30161
HOUSTON, THOMAS P. 27 ACT FP
302 TURNER MCCALL BLVD, ROME 30161
HOWSE, RALPH M. 27 ACT U
1825 MARTHA BERRY HWY, ROME 30161
HYDEN, WILLIAM U. 27 ACT GP
SIMMONS ST #11, TRION 30753
JACKSON, THOMAS W. 27 ACT OBG
320 WEST NINTH ST, ROME 30161
JORDAN, WILLIS P., III 27 ACT OBG
10 HOSPITAL CIR, ROME 30161
KELLEY, JAMES M. 27 ACT ORS
310 WEST TENTH ST, ROME 30161
KIRKLANO, JOHN S. 27 ACT CDS
1825 MARTHA BERRY BLVD, ROME 30161
LAWRENCE, DOUGLAS R. 27 ACT OBG
1105 NORTH 5TH AVE, ROME 30161
LEIGH, RICHARD W. 27 ACT OBG
909 NORTH FIFTH AVE, ROME 30161
LEWIS, JOHN GRANT 27 ACT IM
5 JOHN MADDOX DR, ROME 30161
LITTLE, G.H. 27 ACT FP
15 PARK AVE, TRION 30753
LLORENTE, TEODULO M. 27 ACT FP
105 JOHN MADDOX DR, ROME 30161
LOWREY, DARRELL G. 27 ACT ORS
1825 MARTHA BERRY BLVD, ROME 30161
LUCAS, WILLIAM H. 27 ACT IM
5 PROFESSIONAL CT, ROME 30163
LYNN, RONALD B. 27 ACT N
327 TURNER MCCALL BLVD, ROME 30161
MACLEOO, DAVID S. 27 ACT CD
HARBIN CLINIC, ROME 30161
MARTENS, LESTER J. 27 ACT IM
321 TURNER MCCALL BLVD, ROME 30161
MATHENY, JAMES T. 27 ACT PD
16 HOSPITAL CIR, ROME 30161
MCGEHEE, JOHN M. 27 ACT GS
223 JULE PEEK AVE, CEDARTOWN 30125
MCMILLIAN, JAMES R. 27 ACT PD
HARBIN CLINIC, ROME 30161
MOORE, C.W.C. 27 ACT IM
304 EAST SECOND AVE, ROME 30161
MORGAN, TOBY S. 27 ACT OTO
107 JOHN MADDOX DR, ROME 30161
MOSS, T.H., SR. 27 ACT OBG
409 SOUTH BROAD ST, ROME 30161
MOSS, THOMAS H., JR. 27 ACT FP
409 SOUTH BROAD ST, ROME 30161
NORTON, R.F. 27 R OBG
514 COOPER DR, ROME 30161
PATEL, DILIPKUMAR R. 27 ACT PD
316 WEST TENTH ST, ROME 30161
PERKINS, G.E., II 27 ACT PUD
5 CRESTWOOD DR, ROME 30161
PITTMAN, HOUSTON H. 27 ACT NS
HARBIN CLINIC, ROME 30161
PRATT, FRANK G., JR. 27 ACT P
HARBIN CLINIC, ROME 30161
PRATT, SUZANNE 27 ACT OBG
909 NORTH FIFTH AVE, ROME 30161
RHODES, E. LEON 27 ACT GS
HARBIN CLINIC, ROME 30161
RICHAROS, CHARLES K. 27 ACT R
1104 MARTHA BERRY BLVD, ROME 30161
RIGAS, LAMBROS C. 27 ACT OBG
316 WEST TENTH ST, ROME 30161
ROGERS, D.MICHAEL 27 ACT GS
1825 MARTHA BERRY BLVD, ROME 30161
ROGERS, JIM LEE 27 ACT OBG
1105 NORTH FIFTH AVE, ROME 30161
ROUTLEOGE, JAMES A. 27 ACT GS
310 WEST SIXTH ST, ROME 30161
SANCHEZ, ELIO S. 27 ACT IM
6 COACH TR SE, ROME 30161
SCHMIOT, OON 27 S FP
NAVAL HOSPITAL, MILLINGTON TN 38054
SELF, STANLEY J. 27 ACT D
302 WEST SIXTH ST, ROME 30161
SENNETT, CHARLIE O., JR. 27 ACT PTH
FLOYD HOSPITAL, ROME 30161
SMITH, CHARLES M. 27 ACT FP
530 HUNTER ST, ROCKMART 30153
SMITH, LUCIUS S. 27 ACT R
FLOYD HOSPITAL, ROME 30162
SMITH, ROBERT E. 27 ACT FP
302 TURNER MCCALL BLVD, ROME 30161
SMITH, STEPHEN D. 27 ACT PD
10 HORSELEG CREEK RD, ROME 30163
SMITH, STUART A. 27 ACT OTO
15 JOHN MADDOX DR, ROME 30161
SPIVEY, HERMAN E. 27 ACT FP
PO BOX 409, SUMMERVILLE 30747
STARR, HARLAN M. 27 ACT PD
16 HOSPITAL CIR, ROME 30161
STARR, TRAMWELL, III 27 ACT PUD
1825 MARTHA BERRY BLVD, ROME 30161
STEGALL, FRANK D. 27 ACT CD
HARBIN CLINIC, ROME 30161
STERGUS, INGRID 27 ACT PTH
316 MOUNT ALTO RD, ROME 30161
TATE, JOHN D. 27 ACT FP
14 HOSPITAL CIR, ROME 30161
TODINO, JOEL D. 27 ACT IM
11 JOHN MADDOX DR, ROME 30161
VOSS, CRAIG A. 27 ACT PTH
321 TURNER MCCALL BLVD, ROME 30161
WALDREP, JACK MARION 27 ACT U
101 JOHN MADDOX DR, ROME 30161
WARD, BRADLEY L. 27 ACT FP
PO BOX 130, TAYLORSVILLE 30178
WATERS, RAYMOND O. 27 ACT OTO
15 JOHN MADDOX DR, ROME 30161
WEAVER, JERRY O. 27 ACT FP
502 NORTH MAIN ST, CEDARTOWN 30125
WHATLEY, JAMES C. 27 ACT IM
1825 MARTHA BERRY BLVD, ROME 30161
WILCOX, C.R. 27 ACT OBG
10 HOSPITAL CIR, ROME 30161
WOOOS, JOHN TERRANCE 27 ACT R
1104 MARTHA BERRY BLVD, ROME 30161
WYATT, BARBARA 27 ACT IM
3 PROFESSIONAL CT, ROME 30161
WYATT, C.J., JR. 27 ACT IM
3 PROFESSIONAL CT, ROME 30161
YOUNG, R.A. 27 ACT CD
203 PINE VALLEY RD, ROME 30161

28—FRANKLIN

CHAO, YU-CHIA 28 ACT FP
350 CHURCH ST, ROYSTON 30662
CRUMP, HOYT W. 28 ACT FP,EM
350 CHURCH ST, ROYSTON 30662
HARRIS, WESLEY W. 28 ACT FP
350 CHURCH ST, ROYSTON 30662
SHARPTON, JULIAN O. 28 ACT FP
PO BOX 938, HARTWELL 30643
SULLIVAN, ROBERT F. 28 ACT US
10 ROYSTON RD, CARNESVILLE 30521

29—MEDICAL ASSN OF ATLANTA

ABEL, RICHARO W. 29 ACT PD
5635 PEACHTREE PKY, NORCROSS 30071
ABEND, MELVIN N. 29 ACT GS
4553 NORTH SHALLOWFORD RD, ATLANTA 30338
ABERNATHY, A.H., III 29 ACT IM
105 COLLIER RD NW STE 1060, ATLANTA 30309
ADAIR, HAROLO E. 29 ACT U
960 JOHNSON FERRY RD NE, ATLANTA 30342
ADAMS, CHARLES P. 29 ACT GS
490 PEACHTREE ST NE #278-C, ATLANTA 30308
ADAMS, DANIEL M. 29 ACT OTO
2719 FELTON DR, EAST POINT 30344
AOAMS, ELIZABETH K. 29 S IM
730 PEACHTREE ST NE, ATLANTA 30365
ADERHOLT, HEWLETT EDWIN 29 ACT AN
1968 PEACHTREE RD NW, ATLANTA 30309
ADLER, SAUL M. 29 ACT OS
5675 PEACHTREE DUNWOODY RD, ATLANTA 30342
AHMANN, PETER A. 29 ACT CHN
1365 CLIFTON RD NE, ATLANTA 30322
AHN, YOUNG W. 29 ACT OBG
25 PRESCOTT ST NE, ATLANTA 30308
AKIN, JOHN T., JR. 29 ACT GS
35 COLLIER RD NW, ATLANTA 30309
ALARCON, ALFREDO 29 ACT CDS
490 PEACHTREE ST NE, ATLANTA 30308
ALBEE, ROBERT B., JR. 29 ACT OBG
20 LINDEN AVE NE STE 7-C, ATLANTA 30365
ALDEN, HERBERT S. 29 ACT D
3316 PIEDMONT RD NE STE 520, ATLANTA 30305
ALDERETE, JOSEPH F. 29 S P
1670 CLAIRMONT RD, DECATUR 30030
ALDERMAN, EARL L. 29 ACT GS
35 COLLIER RD NW, ATLANTA 30309
ALEXANDER, HAROLO H. 29 ACT ORS
6500 VERNON WOODS DR NE, ATLANTA 30328
ALEXANDER, JAMES H. 29 ACT PD
5675 PEACHTREE-DUNWOODY RD, ATLANTA 30342
ALFREO, DEWITT C., JR. 29 ACT P
80 BUTLER ST SE, ATLANTA 30335

ALLAN, CHRISTOPHER J. 29 ACT PTH
1000 JOHNSON-FERRY RD, ATLANTA 30342
ALLEN, ROBERT C. 29 ACT OPH
1365 CLIFTON RD NE, ATLANTA 30322
ALLGOOD, PIERCE 29 ACT ORS
35 COLLIER RD NW, ATLANTA 30309
ALLMAN, FRED L. 29 ACT ORS
615 PEACHTREE ST NE STE 1100, ATLANTA 30308
ALPERIN, HERBERT 29 ACT PD
5675 PEACHTREE-DUNWOODY RD, ATLANTA 30342
ALPERT, HAROLD M. 29 ACT PUD
3250 HOWELL MILL RD STE 105, ATLANTA 30327
AMBROSE, SAMUEL S., JR. 29 ACT U
1365 CLIFTON RD NE, ATLANTA 30322
AMERSON, J. RICHARD 29 ACT GS
EMORY UNIVERSITY CLINIC, ATLANTA 30322
AMIR-ATEFI, DAVID 29 ACT
3993 LAWRENCEVILLE HWY, LILBURN 30247
AMMONS, JOHN C. 29 S N
1670 CLAIRMONT RD NE, DECATUR 30033
ANASTASIADES, K. DINOS 29 I&R
3922 WEST WOOD PATH, STONE MOUNTAIN 30083
ANDERS, PATRICK L. 29 ACT OBG
2726-A FELTON DR, EAST POINT 30344
ANDERS, REBEKAH Y. 29 ACT FP
2726-A FELTON DR, EAST POINT 30344
ANDERSON, GROVER L. 29 ACT NS
315 BOULEVARD NE STE 300, ATLANTA 30312
ANDERSON, H. VERNON 29 I&R
2502 KINGSCLIFF DR, ATLANTA 30345
ANDERSON, JAMES D., JR.(DDS) 29 AF
6075 ROSWELL RD NE, ATLANTA 30328
ANDERSON, THOMAS J., JR. 29 ACT IM
490 PEACHTREE ST NE, ATLANTA 30308
ANDERSON, WALTER F. 29 S P
2531 BRIARCLIFF RD NE, ATLANTA 30329
ANDERSON, WILLIAM B. 29 ACT P
1462 MONTREAL RD, TUCKER 30084
ANSARI, AMIR H. 29 ACT OBG
300 BOULEVARD NE, ATLANTA 30312
ANTON, BLANCA R. 29 ACT CHP
1970 CLIFF VALLEY WAY NE, ATLANTA 30329
ANTON, MANUEL P. 29 A P
99 BUTLER ST SE, ATLANTA 30303
APPELROUTH, DANIEL J. 29 ACT RHU
993-D JOHNSON FERRY RD NE, ATLANTA 30342
ARANGO, VIRGILIO A. 29 ACT PD
35 LINDEN AVE NE, ATLANTA 30308
ARSEVEN, H. OGUZ 29 ACT AN
PO BOX 743, LITHIA SPRINGS 30057
ARSHAD, MOHAMMAD 29 ACT OBG
804 MAIN ST 'B, FOREST PARK 30050
ASHER, HAROLD 29 ACT GE
5669 PEACHTREE-DUNWOODY RD, ATLANTA 30342
ASKREN, EDWARD L., JR. 29 ACT OPH
1293 PEACHTREE ST NE, ATLANTA 30309
ATKINS, SAM O. 29 ACT U
2600 ML KING JR BLVD SW, ATLANTA 30311
ATKINSON, GEORGE O. 29 ACT PDR
1405 CLIFTON RD NE, ATLANTA 30322
ATKINSON, STEWART 29 ACT OPH
615 PEACHTREE ST NE, ATLANTA 30308
ATWATER, JOHN S. 29 ACT IM,GE
478 PEACHTREE ST NE, ATLANTA 30308
ATWATER, PAUL C. 29 ACT OTO
105 COLLIER RD NW STE 4040, ATLANTA 30309
AUDA, STEPHEN P. 29 ACT GS,ON
100 NORTH PARK CENTER, FAYETTEVILLE 30214
AUSTIN, COLLEEN S. 29 ACT IM
5669 PEACHTREE DUNWOODY RD, ATLANTA 30342
AVERETT, JAMES E., JR. 29 ACT ORS
105 COLLIER RD NW STE 2010, ATLANTA 30309
AVERY, WILLIAM G. 29 ACT GYN
275 CARPENTER DR NE, ATLANTA 30328
AYER, G. DARRELL, JR. 29 ACT PTH
BOX 12466, ATLANTA 30355
AYERS, GARY R. 29 ACT TR
1000 JOHNSON FERRY RD NE, ATLANTA 30342
AZAR, GORDON J. 29 ACT IM
960 JOHNSON FERRY RD NE, ATLANTA 30342
BABALIAROS, CONSTANTINE N. 29 ACT GS
1203 CLEVELAND AVE ' 1-B, EAST POINT 30344
BACKERMAN, IVAN A. 29 ACT OBG
1311 CLEVELAND AVE, EAST POINT 30344
BAILEY, JAMES A. 29 ACT PM
1368 OAKCREST DR SW, ATLANTA 30311
BAIRD, JOSEPH B., JR. 29 ACT P
1938 PEACHTREE RD NW, ATLANTA 30309
BAIRD, L. STEPHENS 29 ACT GS
1835 DELOWE DR SW, ATLANTA 30311
BAKER, J. JAY 29 ACT ON
993-D JOHNSON FERRY RD NE, ATLANTA 30342
BAKER, LAWRENCE D. 29 ACT GP
2150 PEACHFORD RD STE B, ATLANTA 30338
BALBONA, JOSE L. 29 ACT P
1935 CLIFF VALLEY WAY NE, ATLANTA 30329
BALCH, THOMAS S. 29 ACT IM
3280 HOWELL MILL RD NW, ATLANTA 30327
BALL, TURNER I. 29 ACT PDR
1405 CLIFTON RD NE, ATLANTA 30322
BALLARD, JULIA E. 29 ACT IM
1968 PEACHTREE RD, ATLANTA 30309
BALLARD, MARGUERITE C. 29 S IM
3092 ARGONNE DR NW, ATLANTA 30305
BANCKER, EVERT A. 29 ACT IM
125 RIVER NORTH DR NW, ATLANTA 30328
BARKSDALE, C.R., JR. 29 R FP
RICO LAKE RD, PALMETTO 30268
BARNES, JOHN J. 29 ACT OBG
2045 PEACHTREE RD NE, ATLANTA 30309
BARNES, JOSEPH H. 29 ACT OBG
993 JOHNSON FERRY RD NE, ATLANTA 30342
BARNETT, CRAWFORD F., JR. 29 ACT IM
3250 HOWELL MILL RD NW, ATLANTA 30327
BARNETT, JOHN E., JR. 29 ACT P
6363 ROSWELL RD NE, ATLANTA 30328
BARNETT, STEPHEN M. 29 ACT GS
105 COLLIER RD NW, ATLANTA 30309
BARNETT, STEPHEN T., JR. 29 ACT OBG
PO BOX 1424, HIGHLANDS NC 28741
BARTHOLOMEW, PHILIP R. 29 ACT OBG
960 JOHNSON FERRY RD NE, ATLANTA 30342
BARTON, IRENE D. 29 ACT P
34 BAL BAY DR #8, BAL HARBOUR FL 33154
BASKIN, J. HAGAN 29 ACT CDS
35 COLLIER RD NW STE 385, ATLANTA 30309
BATEMAN, NEEDHAM B. 29 ACT GS
573 WEST PEACHTREE ST NW, ATLANTA 30308
BATTEY, PATRICK M. 29 I&R
GRADY MEMORIAL HOSPITAL, ATLANTA 30303
BAUMGARTNER, BRUCE R. 29 ACT R
1365 CLIFTON RD NE, ATLANTA 30322
BAUTE, ANTONIO V. 29 ACT IM,CD
1100 CLEVELAND AVE ' 200, EAST POINT 30344
BAYNE, LOUI G. 29 ACT ORS
960 JOHNSON FERRY RD NE, ATLANTA 30342
BEAN, JAMES L. 29 ACT OBG
PO BOX 5047, ROSWELL 30077
BEASLEY, ERNEST W., JR. 29 ACT IM,END
478 PEACHTREE ST NE, ATLANTA 30308
BECKER, BRUCE H. 29 ACT OPH
3280 HOWELL MILL RD STE 243, ATLANTA 30327
BEDELL, DAVID T. 29 ACT P
777 CLEVELAND AVE SW, ATLANTA 30315
BELL, FRANK C. 29 ACT OPH
5675 PEACHTREE DUNWOODY RD, ATLANTA 30342
BELL, HUGH V., JR. 29 ACT PTH
2736 FELTON DR, EAST POINT 30344
BENIGNO, BENEDICT B. 29 ACT GYN
993-F JOHNSON FERRY RD, ATLANTA 30342
BENNETT, RICHARD G. 29 ACT OS
5667 PEACHTREE DUNWOODY RD, ATLANTA 30342
BENNETT, WILLIAM H. 29 ACT U
6 HOWELL MILL PLANTATION, ATLANTA 30327
BENSON, H. BAGLEY 29 ACT PD
5675 PEACHTREE-DUNWOODY RD, ATLANTA 30342
BENSON, KENNETH C. 29 ACT OPH
5635 PEACHTREE PKY STE 180, NORCROSS 30092
BERENSON, JOEL E. 29 ACT DR
300 BOULEVARD NE, ATLANTA 30312
BERGER, LOUIS 29 ACT OPH
1218 BRIAR HILLS DR NE, ATLANTA 30306
BERGHERM, BRUCE A. 29 ACT AN
5745 WINTERTHUR LN NW, ATLANTA 30328
BERGMAN, BERNARD A. 29 ACT CHP,P
3280 HOWELL MILL RD STE 230, ATLANTA 30327
BERMAN, JEROME D. 29 R PD
9715 HUNTCLIFF TR, DUNWOODY 30338
BERN, GERHARD O. 29 R IM
275 FIFTH ST NW, ATLANTA 30318
BERNSTEIN, JEFFREY A. 29 ACT OBG
2550 WINDY HILL RD STE 206, MARIETTA 30067
BERNSTEIN, RICHARD B. 29 ACT N
3280 HOWELL MILL RD NW, ATLANTA 30327
BERRY, ARNOLD J. 29 ACT AN
1364 CLIFTON RD NE, ATLANTA 30322
BERRY, C. MARKHAM 29 ACT P
6111 PEACHTREE DUNWOODY RD, ATLANTA 30328
BERRY, J. NORMAN 29 ACT IM
6500 VERNON WOODS DR NE, ATLANTA 30328
BERRY, MAXWELL R., JR. 29 R GE
BOX 1099, BIG CANOE 30143
BETHEA, JAMES S., III 29 ACT ORS
5669 PEACHTREE-DUNWOODY RD, ATLANTA 30342
BICKERS, DONALD 29 ACT NS
3250 HOWELL MILL RD NW, ATLANTA 30327
BIENERT, HENRY J. 29 ACT ORS
1311 CLEVELAND AVE, EAST POINT 30344
BIGGERS, WILLIAM H. 29 ACT P
3280 HOWELL MILL RD STE 230, ATLANTA 30327
BIKOFF, WILLIAM S. 29 ACT N
315 BOULEVARD NE STE 224, ATLANTA 30312
BILSTEN, GEORGE G.B. 29 ACT N
35 COLLIER RD NW, ATLANTA 30309
BISHOP, LINTON H., JR. 29 ACT IM
490 PEACHTREE ST NE, ATLANTA 30308
BIVENS, EDWARD S. 29 ACT R
1692 EAST CLIFTON RD NE, ATLANTA 30307
BIVINGS, F. LEE 29 ACT PD
3110 HABERSHAM RD NW, ATLANTA 30309
BLACK, JUDSON G. 29 ACT IM
3250 HOWELL MILL RD NW 305, ATLANTA 30327
BLACK, PAUL W. 29 ACT PS
993-C JOHNSON FERRY RD NE, ATLANTA 30342
BLAINE, B.C. 29 ACT IM
2018 HOLLYWOOD RD NW, ATLANTA 30318
BLALOCK, JOHN C. 29 ACT GS
2637 PEACHTREE RD NE APT 110, ATLANTA 30305
BLALOCK, TULLY T. 29 ACT IM
3280 HOWELL MILL RD NW 217, ATLANTA 30327
BLAND, JAMES W., JR. 29 ACT AN
1405 CLIFTON RD NE, ATLANTA 30322
BLANK, SAMUEL 29 S OS
1670 CLAIRMONT RD NE, DECATUR 30033
BLANK, STEPHEN C. 29 ACT OBG
315 BOULEVARD NE STE 328, ATLANTA 30312
BLEICH, ALLAN C. 29 ACT IM
5669 PEACHTREE-DUNWOODY RD, ATLANTA 30342
BLEICH, J.K. 29 ACT IM
490 PEACHTREE ST, STE 229-B, ATLANTA 30308
BLOCK, DONALD L. 29 ACT OBG
1175 PEACHTREE ST NE, ATLANTA 30361
BLOODWORTH, RONALD C. 29 ACT P
3188 ATLANTA ST SE, SMYRNA 30080
BLUMBERG, MAX M. 29 ACT IM
490 PEACHTREE ST STE 371-C, ATLANTA 30308
BOBRAKOV, EREM E. 29 ACT FP
573 WEST PEACHTREE ST NE, ATLANTA 30308

BOGER, RICHARO E. 29 ACT PD
5675 PEACHTREE-DUNWOODY RD, ATLANTA 30342
BOGER, ROBERT M. 29 S IM
1670 CLAIRMONT RD, DECATUR 30033
BOLING, BARBARA E. 29 ACT IM
3810 PLEASANTDALE RD, ATLANTA 30340
BONDELL, STEVEN P. 29 ACT PTH
340 BOULEVARD NE STE 318, ATLANTA 30312
BONDURANT, H. WILLIAM 29 ACT ORS
478 PEACHTREE ST NE, ATLANTA 30308
BONE, DAVIO K. 29 ACT CDS
5669 PEACHTREE DUNWOODY RD, ATLANTA 30342
BONNER, JOHN T. 29 ACT AN
1670 CLAIRMONT RD, DECATUR 30033
BOOTH, ARTHUR S., JR. 29 ACT GS
993 JOHNSON FERRY RD NE, ATLANTA 30342
BOOTLE, JAMES C. 29 ACT PTH
PO BOX 80846, ATLANTA 30366
BORDERS, JUEL PATE 29 ACT OBG
991 MLK JR DR, ATLANTA 30314
BORDON, JOSE ANTONIO 29 R AN
830 MOUNT VERNON HWY NW, ATLANTA 30327
BOSTWICK, JOHN, III 29 ACT PS
25 PRESCOTT ST NE, ATLANTA 30308
BOSWELL, JOHN R. 29 R AN
292 ACADEMY ST, MADISON 30650
BOWEN, EOWARO G. 29 ACT OBG
960 JOHNSON FERRY RD NE, ATLANTA 30342
BOWLES, STEPHEN M. 29 ACT AN
35 LINDEN AVE NE, ATLANTA 30308
BOYETT, JAMES E. 29 ACT TS
1603 WARE AVE, EAST POINT 30344
BOYLE, LAWRENCE P. 29 ACT GS
105 COLLIER RD NW, ATLANTA 30309
BRACKETT, J. GORDON 29 ACT OTO
340 BOULEVARD NE, ATLANTA 30312
BRACKETT, MORRIS E. 29 R OBG,PH
5505 MOUNT VERNON PKY NW, ATLANTA 30327
BRANDENBURG, DAVID S. 29 ACT GE
5667 PEACHTREE-DUNWOODY RD, ATLANTA 30342
BRANTLEY, MARVIN A., III 29 ACT P
1365 CLIFTON RD NE, ATLANTA 30322
BRASWELL, L. RENOER 29 ACT FP
143 WEST PACES FERRY RD NW, ATLANTA 30305
BRAUN, IRA F. 29 ACT R
1365 CLIFTON RD NE, ATLANTA 30322
BRAWNER, JAMES N., III 29 A IM
35 COLLIER RD NW STE 775, ATLANTA 30367
BREWER, SPENCER S., JR. 29 ACT IM
1938 PEACHTREE RD NW, ATLANTA 30309
BRIANT, THOMAS P. 29 ACT AN
35 COLLIER RD NW STE 560, ATLANTA 30309
BRIDGES, GLENN J. 29 ACT U
573 WEST PEACHTREE ST NE, ATLANTA 30308
BRIGMAN, JAMES A., JR. 29 ACT U
993-F JOHNSON FERRY RD NE, ATLANTA 30342
BRINSFIELD, OOROTHY 29 ACT PDC
EMORY UNIVERSITY CLINIC, ATLANTA 30322
BROOY, HAROLD J. 29 ACT D
478 PEACHTREE ST STE 711-A, ATLANTA 30308
BROOKS, W. SCOTT, JR. 29 ACT IM
1365 CLIFTON RD NE, ATLANTA 30322
BROOME, HARRY L. 29 ACT ORS
960 JOHNSON FERRY RD NE, ATLANTA 30342
BROWN, ALGIE C. 29 ACT D
817 DOUGLAS RD NE, ATLANTA 30342
BROWN, BOBBY C. 29 ACT PTH
1968 PEACHTREE RD NW, ATLANTA 30309
BROWN, CHARLES E. 29 ACT IM
21 EIGHTH ST NE, ATLANTA 30309
BROWN, CHARLES W. 29 ACT ORS
478 PEACHTREE ST NE, ATLANTA 30308
BROWN, H. EUGENE 29 R IM
622 PARK LN, DECATUR 30033
BROWN, HOWARO S. 29 ACT TS
5669 PEACHTREE-DUNWOODY RD, ATLANTA 30342
BROWN, JIMMY S. 29 ACT PD
3162 PIEDMONT RD, ATLANTA 30305
BROWN, LESTER A. 29 ACT OTO
490 PEACHTREE ST NE, ATLANTA 30308
BROWN, MORRIS E. 29 ACT IM
1372 PEACHTREE ST NE, ATLANTA 30309
BROWN, NELSON H. 29 ACT IM
478 PEACHTREE ST NE, ATLANTA 30308
BROWN, NYDA WILLIAMS 29 ACT P
106 PEACHTREE BATTLE AVE NW, ATLANTA 30305
BROWN, ROBERT H. 29 ACT OTO
3280 HOWELL MILL RD NW, ATLANTA 30327
BROWN, ROBERT L. 29 R GS
321 ROBIN HOOD RD NE, ATLANTA 30309
BROWN, SAMUEL B. 29 ACT P
450 EAST PACES FERRY RD NE, ATLANTA 30305
BRUCKNER, EVERT A. 29 AF ON
HOSPITAL VOANDES-CASILLA 691, QUITO ECUADOR
BRUMLEY, GEORGE W. 29 ACT PD
2040 RIDGEWOOD DR NE, ATLANTA 30322
BRUNER, BARBARA 29 A PD
69 BUTLER ST SE, ATLANTA 30303
BRUNT, GWYNNE T., JR. 29 ACT R,NM
1000 JOHNSON FERRY RD NE, ATLANTA 30342
BRYANT, MILTON F. 29 ACT GS
35 COLLIER RD NW, ATLANTA 30309
BUNNEN, ROBERT L., DDS 29 AF GS
3312 PIEDMONT RD NE, ATLANTA 30305
BURGE, DAN 29 ACT IM
315 BOULEVARD NE, ATLANTA 30312
BURNS, WILLIAM B., JR. 29 ACT IM
35 COLLIER RD NW, ATLANTA 30309
BURRELL, MATTHEW O. 29 ACT ON
5669 PEACHTREE-DUNWOODY RD, ATLANTA 30342
BURSON, E. NAPIER, JR. 29 ACT IM
5669 PEACHTREE-DUNWOODY RD, ATLANTA 30342
BURTON, HERBERT W. 29 R IM
5115 LONG ISLAND DR NW, ATLANTA 30308
BUSEY, THOMAS J., JR. 29 ACT U
2748-B FELTON DR, ATLANTA 30344
BUSH, OWANA M. 29 ACT FP
90 WEST WIEUCA RD, ATLANTA 30342
BUSSEY, JOHN R. 29 ACT EM
48 INMAN CIR NE, ATLANTA 30309
BUTLER, CHARLES W., JR. 29 ACT OBG
5675 PEACHTREE-DUNWOODY RD, ATLANTA 30342
BUTLER, ELIZABETH D. 29 I&R IM
792 MARSTEVAN DR, ATLANTA 30306
BUTLER, RICHARO H. 29 S AM
1048-B NORTH JAMESTOWN RD, DECATUR 30033
BUTLER, WALTER H. 29 ACT AN
35 COLLIER RD NW STE 560, ATLANTA 30309
BYERS, KATHLEEN 29 R AN
396 WIMBLEDON RD NE, ATLANTA 30324
BYRD, M. DANIEL 29 ACT IM
340 BOULEVARD NE, ATLANTA 30312
BYRNES, WILLIAM F. 29 ACT AN
2760-B FELTON DR, EAST POINT 30344
CABEZAS, ROORIGO 29 ACT TS,CDS
5669 PEACHTREE-DUNWOODY RD, ATLANTA 30342
CADIER, THOMAS R. 29 ACT ORS
4555 NORTH SHALLOWFORD RD, DUNWOODY 30338
CALHOUN, CLYDE R., JR. 29 ACT OBG
993-D JOHNSON FERRY RD, ATLANTA 30342
CALHOUN, F.P., JR. 29 ACT OPH
25 PRESCOTT ST NE, ATLANTA 30308
CALLAWAY, GEORGE M., JR. 29 S IM
1670 CLAIRMONT RD NE, DECATUR 30033
CAMERON, E. CHRISTIAN 29 ACT IM
3280 HOWELL MILL RD NW, ATLANTA 30327
CAMPBELL, DAVID G. 29 ACT OPH
1365 CLIFTON RD NE, ATLANTA 30322
CAMPBELL, WALLACE G. 29 ACT PTH
EMORY UNIV SCHOOL OF MED, ATLANTA 30322
CANTWELL, JOHN DAVIS 29 ACT CD
300 BOULEVARD NE, ATLANTA 30312
CAPLAN, DANIEL B. 29 ACT PD
2040 RIDGEWOOD DR NE, ATLANTA 30322
CAPPARELL, ROBERT 29 ACT ID
993-D JOHNSON FERRY RD, ATLANTA 30342
CAPUTO, RAYMOND V. 29 ACT D
960 JOHNSON FERRY RD STE 450, ATLANTA 30342
CARABAJAL, NESTOR R. 29 ACT CDS
5669 PEACHTREE-DUNWOODY RD, ATLANTA 30342
CARLISLE, O.B. 29 ACT OPH
3169 MAPLE DR NE, ATLANTA 30305
CARLOCK, KELLER S. 29 ACT PD
3162 PIEDMONT RD NE, ATLANTA 30305
CARR, DANIEL J. 29 ACT IM
105 COLLIER RD NW STE 4080, ATLANTA 30309
CARR, RICHARO D. 29 S PM
3744 PREAKNESS DR, DECATUR 30034
CARROLL, M. SCOTT 29 ACT A
6667 VERNON WOODS DR NE, ATLANTA 30328
CARSON, JAMES MAXWELL 29 ACT IM
340 BOULEVARD NE, ATLANTA 30312
CARTER, A.W., JR. 29 ACT FP
4932 PHILLIPS DR, FOREST PARK 30050
CARTER, JAMES A. 29 ACT OTO
35 COLLIER RD NW, ATLANTA 30309
CARTER, ROY G. 29 ACT P
340 BOULEVARD STE 307, ATLANTA 30312
CARTER, SANOY B. 29 R IM
355 LONDONBERRY RD NW, ATLANTA 30327
CARTER, SANOY B., JR. 29 ACT IM
6500 VERNON WOODS DR NE, ATLANTA 30328
CASARELLA, WILLIAM J. 29 ACT R
1364 CLIFTON RD, ATLANTA 30322
CASSIOY, BRUCE A. 29 ACT IM
105 COLLIER RD NW STE 2040, ATLANTA 30309
CATANZARO, MARSHALL J. 29 ACT R
1000 JOHNSON FERRY RD NE, ATLANTA 30342
CAUOILL, OARRELL R. 29 ACT TS
315 BOULEVARD NE STE 528, ATLANTA 30312
CAVANAGH, HARRISON O. 29 ACT OS
1365 CLIFTON RD NE, ATLANTA 30322
CERTAIN, MARSHA J. 29 I&R IM
80 BUTLER ST SE, ATLANTA 30303
CHAIT, DONALD C. 29 ACT IM,HEM
478 PEACHTREE ST NE, ATLANTA 30308
CHALMERS, RIVES 29 ACT P
2905 PEACHTREE RD NE, ATLANTA 30305
CHAMBERS, BENJAMIN M. 29 ACT OPH
490 PEACHTREE ST STE 242-B, ATLANTA 30308
CHAMBERS, DONN A. 29 ACT AN
5665 PEACHTREE DUNWOODY RD, ATLANTA 30342
CHANDLER, NEAL W. 29 ACT DR
4680 RIVERVIEW RD NW, ATLANTA 30327
CHAPMAN, RODGER W. 29 ACT EM,IM
340 BOULEVARD NE #135, ATLANTA 30312
CHAPPELL, AMEY 29 ACT IM
3750 PEACHTREE ST NE, ATLANTA 30319
CHELTON, ALICE G. 29 ACT P
1970 CLIFF VALLEY WAY NE, ATLANTA 30329
CHELTON, L. GUY 29 ACT IM
755 COLUMBIA DR STE 302, DECATUR 30030
CHEVES, H.L. 29 ACT FP
2726-B FELTON DR, EAST POINT 30344
CHORCHES, MICHAEL A. 29 ACT CD
5665 PEACHTREE-DUNWOODY RD, ATLANTA 30342
CHOTINER, GERALD 29 ACT D
3250 HOWELL MILL RD NW, ATLANTA 30327
CHRISTY, JAMES H. 29 ACT IM
1365 CLIFTON RD NE, ATLANTA 30322
CIBIK, GEORGE M. 29 ACT IM,GE
3250 HOWELL MILL RD NW, ATLANTA 30327
CIOFFI, CYRUS M. 29 ACT R
315 BOULEVARD NE, ATLANTA 30312
CITRON, JOSEPH 29 ACT OPH
571 WEST PEACHTREE ST NW, ATLANTA 30308
CLAIBORNE, T. STERLING 29 ACT IM
455 WEST WESLEY RD NW, ATLANTA 30305

CLAIBORNE, THOMAS S., JR. 29 ACT IM,GE
35 COLLIER RD NW STE 650, ATLANTA 30309
CLAIR, ALVIN H. 29 ACT D
777 CLEVELAND AVE #500, ATLANTA 30315
CLAIRMONT, ALBERT A. 29 ACT OTO
25 PRESCOTT ST NE STE 6404, ATLANTA 30308
CLARK, ALAN D. 29 ACT GP,EM

CLARK, JAMES E. 29 ACT IM
35 COLLIER RD NW, ATLANTA 30309
CLARK, NEWTON T., JR. 29 ACT ORS
993 JOHNSON FERRY RD NE, ATLANTA 30342
CLARK, TERESA E. 29 ACT IM
490 PEACHTREE ST NE, ATLANTA 30308
CLEMENTS, J.L., JR. 29 ACT R
80 BUTLER ST SE, ATLANTA 30303
CLEMENTS, STEPHEN D. 29 ACT CD
1365 CLIFTON RD NE, ATLANTA 30322
CLINE, STEVEN G. 29 ACT R
1170 CLEVELAND AVE, EAST POINT 30344
CLINKSCALES, GRADY S., JR. 29 ACT ORS
3707 TUXEDO RD NW, ATLANTA 30305
COAN, MARK G. 29 ACT GS
4536 CHAMBLEE-DUNWOODY RD, ATLANTA 30338
COBB, CLAUD P., JR. 29 R FP
201 ANGELA CT, STOCKBRIDGE 30281
COBBS, B. WOODFIN, JR. 29 ACT IM
1365 CLIFTON RD NE, ATLANTA 30322
CODE, REDMOND L.D. 29 I&R R
804 SUMMIT NORTH, ATLANTA 30324
COHEN, DAVID M. 29 ACT OTO
993 JOHNSON FERRY RD NE, ATLANTA 30342
COHEN, I.R. 29 ACT PD
1285 PEACHTREE ST NE STE 127, ATLANTA 30309
COHEN, JACK H. 29 ACT GS
4553 N SHALLOWFORD RD 40-B, ATLANTA 30338
COHEN, PAUL G. 29 ACT IM
993 JOHNSON FERRY RD NE, ATLANTA 30342
COHEN, ROBERT A. 29 ACT IM
2030 PERNOSHAL CT STE D, ATLANTA 30338
COHEN, SHELDON B. 29 ACT P
490 PEACHTREE ST NE, ATLANTA 30308
COHN, MARVIN H. 29 ACT IM
1372 PEACHTREE ST NE, ATLANTA 30309
COLEMAN, JOHN J., III 29 ACT ON
1365 CLIFTON RD NE, ATLANTA 30322
CDLEMAN, REESE C., JR. 29 R U
1328 DOROTHY DR, CLEARWATER FL 33546
COLES, W.C. 29 R R
2606 PIEDMONT RD NE, ATLANTA 30324
COLLENTINE, THOMAS A. 29 ACT EM
5288 HUNTINGFORD CT, MARIETTA 30062
COLLIER, HAL F. 29 ACT R
960 JOHNSON FERRY RD NE, ATLANTA 30342
COLLINS, WILLIAM C. 29 ACT ORS
993 JOHNSON FERRY RD NE, ATLANTA 30342
COMSTOCK, THOMAS W. 29 ACT OTO
3280 HOWELL MILL RD NW, ATLANTA 30327
CONRAD, CONSTANCE C. 29 A PM
PO BOX 23604, ATLANTA 30322
CDOK, RONALD N. 29 ACT IM
490 PEACHTREE ST NE #567-C, ATLANTA 30308
COOK, WILLIAM C., JR. 29 ACT AN
3113 FARMINGTON DR NE, ATLANTA 30339
COOLEDGE, JOHN W. 29 A PD
4770 NORTH PEACHTREE RD, ATLANTA 30338
COOPER, FLOYD R., JR. 29 ACT NS
2718 FELTON DR, EAST POINT 30344
COOPER, GERALD R. 29 S PTH
1600 CLIFTON RD NE, ATLANTA 30333
CODPER, JERRY D. 29 ACT NEP
35 COLLIER RD NW STE 775, ATLANTA 30367
COOPER, LAWRENCE E. 29 ACT IM
2550 WINDY HILL RD STE 210, MARIETTA 30067
COPELAND, FRANK M., JR. 29 ACT P
3280 HOWELL MILL RD STE 109, ATLANTA 30327
COPPEDGE, W.W. 29 ACT OBG
1702 CLEVELAND AVE, EAST POINT 30344
CORLEY, C.C. 29 ACT IM,HEM
110 DOWNSHIRE LN, DECATUR 30033
CORSO, J. ARTURO 29 ACT CD
1100 CLEVELAND AVE #200, EAST POINT 30344
CORTES, JULIO P. 29 ACT AN
353 PARKWAY DR NE, ATLANTA 30312
COTTS, LEONARD L. 29 ACT IM
4536 CHAMBLEE DUNWOODY RD, ATLANTA 30338
COWART, G. THOMAS 29 ACT U
384 PEACHTREE ST NE, ATLANTA 30308
COWGILL, ROBERT 29 ACT ON
5669 PEACHTREE DUNWOODY RD, ATLANTA 30342
COX, GEORGE W. 29 ACT DR
5665 PEACHTREE-DUNWOODY RD, ATLANTA 30342
CRAFTS, BRYAN C. 29 ACT AN
1000 JOHNSON FERRY RD NE, ATLANTA 30342
CRAVER, JDE M. 29 ACT TS
1365 CLIFTON RD NE, ATLANTA 30322
CRAWFORD, CLYDE L. 29 ACT GS
652 WEST PEACHTREE ST NW, ATLANTA 30308
CREWS, EUGENE L., III 29 ACT P
3188 ATLANTA ST SE, SMYRNA 30080
CRIDER, HARRY J., JR. 29 ACT OBG
303 PILGRIM MILL RD, CUMMING 30130
CROFT, BARBARA N. 29 ACT OBG
1938 PEACHTREE RD STE 100, ATLANTA 30309
CROFT, THOMAS J. 29 ACT NS
2718 FELTON DR, EAST POINT 30344
CRONCE, PAUL C. 29 ACT D
3316 PIEDMONT RD NE STE 250, ATLANTA 30305
CROOMS, C.L. 29 ACT ORS
960 JOHNSON FERRY RD NE, ATLANTA 30342
CROSS, G. LEE, III 29 ACT ORS
340 BOULEVARD NE STE 540, ATLANTA 30312
CROSS, JAMES L. 29 ACT OBG
993-D JOHNSON FERRY RD NE, ATLANTA 30342
CROSS, ROBERT N. 29 ACT R
960 JOHNSON FERRY RD NE, ATLANTA 30342
CROW, ROBERT W. 29 ACT PS
1938 PEACHTREE RD STE 208, ATLANTA 30309
CROWE, WILLIAM R. 29 ACT IM
940 FERNCLIFF RD NE, ATLANTA 30324
CRUISE, JOE S. 29 ACT PUD
2491 PACES FERRY RD STE 205, SMYRNA 30080
CRUMBLEY, A.J., JR. 29 ACT GS
2788 BAYARD ST, EAST POINT 30344
CRUTCHER, JAMES C. 29 S IM
1011 RIVERBEND CLUB DR, ATLANTA 30339
CUCHER, BOBB G. 29 ACT IM
993 JOHNSON FERRY RD NE, ATLANTA 30342
CUNNINGHAM, ROBERT P. 29 ACT IM
675 WEST PEACHTREE ST NE, ATLANTA 30308
CURLING, PATRICK E. 29 ACT OS
1364 CLIFTON RD NE, ATLANTA 30322
CURRY, ROBERT H. 29 A PD
69 BUTLER ST SE, ATLANTA 30303
CURRY, SIDNEY S. 29 ACT D
3320 HOLCOMB BRIDGE RD, NORCROSS 30092
CURTIS, EARNEST M., JR. 29 ACT OBG
960 JOHNSON FERRY RD NE, ATLANTA 30342
CURTIS, WALKER L. 29 ACT IM
PO BOX 87100, COLLEGE PARK 30337
D'AUBERMONT, PETER C.S. 29 ACT D
5667 PEACHTREE-DUNWOODY RD, ATLANTA 30342
DALRYMPLE, DAVID E. 29 ACT IM
6500 VERNON WOODS DR NE, ATLANTA 30328
DAVENPORT, T.F. 29 ACT PD
1038 PEACHTREE BATTLE AVE NW, ATLANTA 30327
DAVIDSON, EUGENE D. 29 ACT GS
5669 PEACHTREE-DUNWOODY RD, ATLANTA 30342
DAVIDSON, JOHN A. 29 ACT OPH
3280 HOWELL MILL RD STE 319, ATLANTA 30327
DAVIDSDN, JOHN K., III 29 ACT IM
69 BUTLER ST SE, ATLANTA 30303
DAVIES, NICHOLAS E. 29 ACT IM
35 COLLIER RD NW, ATLANTA 30309
DAVIS, CURTIS L. 29 S GP
215 LAKEWOOD WAY, ATLANTA 30315
DAVIS, DAVE M. 29 ACT P
1938 PEACHTREE RD NW STE 401, ATLANTA 30309
DAVIS, GUY C., JR. 29 ACT AN
35 LINDEN AVE, ATLANTA 30365
DAVIS, JOHN L., III 29 ACT OPH
3250 HOWELL MILL RD NW, ATLANTA 30327
DAVIS, M. BEDFORD, JR. 29 ACT GS
340 BOULEVARD NE, ATLANTA 30312
DAVIS, MARVIN L. 29 ACT PD
5675 PEACHTREE-DUNWOODY RD, ATLANTA 30342
DAVIS, PATRICIA C. 29 ACT R
1365 CLIFTON RD NE, ATLANTA 30322
DAVIS, R. CARTER, JR. 29 ACT IM,GE
25 PRESCOTT ST NE STE 5404, ATLANTA 30365
DAVIS, ROBERT S. 29 ACT OBG
2100 PARKLAKE DR NE, ATLANTA 30345
DAVIS, S. CARTER, JR. 29 ACT IM
1365 CLIFTON RD NE, ATLANTA 30322
DAVIS, W. BEN 29 R PD
2065 WALKER AVE, COLLEGE PARK 30337
DAVIS, WILLIAM A., III 29 ACT R
35 LINDEN AVE NE, ATLANTA 30308
DAWSON, JACK E., JR. 29 ACT CD
478 PEACHTREE ST NE, ATLANTA 30309
DE LA PERRIERE, ARMAND 29 ACT OBG
3604 CHAMBLEE TUCKER RD, CHAMBLEE 30341
DEANDRADE, J. ROBIN 29 ACT ORS
69 BUTLER ST, ATLANTA 30303
DEAS, RALPH H. 29 ACT OPH
3166 MAPLE DR NE, ATLANTA 30305
DEES, HOYT C. 29 ACT OBG
20 LINDEN AVE NE STE 7-C, ATLANTA 30365
DEITCH, MILTON J. 29 ACT U
960 JOHNSON FERRY RD NE, ATLANTA 30342
DEL MAZO, JACINTO 29 ACT IM,GE
490 PEACHTREE ST STE 268-C, ATLANTA 30308
DELASHMUTT, ROBERT E. 29 ACT PTH
340 BOULEVARD NE, ATLANTA 30312
DENMARK, L.D. 29 ACT PD
5605 GLENRIDGE DR NE, ATLANTA 30342
DENNIS, BROWN W. 29 ACT IM
35 COLLIER RD NW, ATLANTA 30309
DENNIS, DONALD P. 29 ACT OTO,OS
3280 HOWELL MILL RD STE 304, ATLANTA 30327
DENNISON, DAVID B. 29 ACT IM
3280 HOWELL MILL RD NW, ATLANTA 30327
DENNISON, DAVID R.M. 29 ACT IM
3280 HOWELL MILL RD STE 217, ATLANTA 30327
DENSLER, JAMES F. 29 ACT PDS
319 WEST LAKE AVE, ATLANTA 30318
DERRICK, BOB L. 29 ACT GS
5669 PEACHTREE-DUNWOODY RD, ATLANTA 30342
DEW, J. HARRIS 29 ACT GS
1293 PEACHTREE ST NE, ATLANTA 30309
DILLE, MICHAEL B. 29 ACT R
960 JOHNSON FERRY RD NE, ATLANTA 30342
DIVINE, RICHARD D. 29 ACT OS
2004 PEACHTREE RD NW, ATLANTA 30367
DOAN, TERRENCE B. 29 ACT GS
993 JOHNSON FERRY RD NE, ATLANTA 30342
DOBES, WILLIAM L., JR. 29 ACT D
478 PEACHTREE ST NE, ATLANTA 30308
DODD, JOHN S., JR. 29 ACT IM
35 COLLIER RD NW, ATLANTA 30309
DOMESCIK, GERALD 29 ACT R,NR
3200 HOWELL MILL RD NW, ATLANTA 30327
DDNNELLY, EDWIN H. 29 ACT OPH
3280 HOWELL MILL RD NW, ATLANTA 30327
DONNELLY, ELWIN W. 29 ACT DR
300 BOULEVARD NE, ATLANTA 30312
DORNEY, EDWARD R. 29 ACT CD
EMORY UNIVERSITY CLINIC, ATLANTA 30322

DOUGLAS, BEVERLY G. 29 ACT OBG
1938 PEACHTREE RD NW, ATLANTA 30309
DDWDA, F. WILLIAM 29 ACT IM
490 PEACHTREE ST NE, ATLANTA 30308
DOWLING, GEORGE B. 29 ACT IM
2600 HOWELL MILL RD NW, ATLANTA 30327
DOWMAN, CHARLES E. 29 ACT NS
2965 SOUTH PHARR CT NW, ATLANTA 30305
DOWMAN, CDRDELIA K. 29 ACT PD
2965 SOUTH PHARR CT NW, ATLANTA 30305
DRAGALIN, DANIEL 29 ACT PD
1375 MIDDLESEX AVE NE, ATLANTA 30306
DRUMMOND, JOHN A. 29 ACT IM,ID
35 COLLIER RD NW STE 425, ATLANTA 30309
DUBOIS, RICHARD E. 29 ACT IM
478 PEACHTREE ST STE 207-A, ATLANTA 30308
DUBOSE, DAVID M. 29 ACT IM
6500 VERNON WOODS DR NE, ATLANTA 30328
DUFFELL, G. MICHAEL 29 ACT IM
1365 CLIFTON RD NE, ATLANTA 30322
DUKE, PEGGY G. 29 ACT AN
35 LINDEN AVE NE, ATLANTA 30365
DULOCK, MALCOLM P. 29 ACT FP
6185 SOUTH BUFORD HWY, NORCROSS 30071
DUNBAR, MARK R. 29 I&R OPH
2031 INNWOOD RD NE, ATLANTA 30329
DUNBAR, RONALD W. 29 ACT AN
20 LINDEN AVE NE STE 725, ATLANTA 30368
DUNBAR, WALTER S. 29 ACT IM
384 PEACHTREE ST NE, ATLANTA 30308
DUNSTAN, EDGAR M. 29 ACT IM
710 PINETREE DR, DECATUR 30030
DURALDE, FERNANDO U. 29 ACT GS
2760 FELTON DR, EAST POINT 30344
DURRETT, DONALD M. 29 ACT DR
1170 CLEVELAND AVE, EAST POINT 30344
DYCKMAN, EDWARD 29 ACT IM
5669 PEACHTREE-DUNWOODY RD, ATLANTA 30342
DYER, WALLACE K., II 29 I&R OTO
2676 WHISPERING PINES CT, DECATUR 30033
EATON, S. BOYD 29 ACT DR
3200 HOWELL MILL RD NW, ATLANTA 30327
ECHEMENDIA, MARIANO M. 29 ACT OBG
384 PEACHTREE ST NE, ATLANTA 30308
EDMONDSON, STEPHEN W. 29 ACT P
4555 NORTH SHALLOWFORD RD, ATLANTA 30338
EDWARDS, WALTER C. 29 ACT ORS
1938 PEACHTREE RD NW, ATLANTA 30309
EHIK, JULIUS 29 ACT P
3985 SOUTH COBB DR STE 120, SMYRNA 30080
EISENBAND, ROBERT M. 29 ACT GE,IM
4555 NORTH SHALLOWFORD RD, ATLANTA 30338
ELLIOTT, RALPH A. 29 R IM
1968 LAVISTA CIR, TUCKER 30084
ELLIS, JOHN O. 29 ACT R
1938 PEACHTREE RD NW STE 111, ATLANTA 30308
ELMER, R.A. 29 ACT R
6500 VERNON WOODS DR NE, ATLANTA 30328
ELSAS, LOUIS J., II 29 A OS
PO DRAWER AM, ATLANTA 30322
ELSEA, WILLIAM R. 29 A PH
99 BUTLER ST SE, ATLANTA 30303
ELSNER, WILLIAM 29 ACT N
237 MEDICAL WAY, RIVERDALE 30274
ELSON, EILEEN F. 29 R FP
12 HOWELL MILL PLANTATION NW, ATLANTA 30327
ENGEL, JDEL S. 29 ACT OBG
7175 DUNHILL TERR NW, ATLANTA 30328
ENGEL, NANCY L. 29 ACT P
2905 PEACHTREE RD NE, ATLANTA 30363
ENGELHARDT, SAMUEL M., III 29 ACT OBG
993 JOHNSON FERRY RD, NE, ATLANTA 30342
EPSTEIN, JACOB 29 ACT OBG
1175 PEACHTREE ST NE, ATLANTA 30309
ERICSSON, JUDITH A. 29 ACT AN
20 LINDEN AVE NE STE 419, ATLANTA 30365

ERMUTLU, ILHAN M. 29 A P
4288 GLENGARY DR NE, ATLANTA 30342
ESPINOZA, FRANK T. 29 ACT GS
3065 AUSTELL RD, MARIETTA 30060
ESTES, J.W. 29 ACT CDS
993 JOHNSON FERRY RD, ATLANTA 30342
ESTES, RICHARD C. 29 ACT U
35 COLLIER RD NW, ATLANTA 30309
EUBANKS, A. BENJAMIN 29 ACT P
1970 CLIFF VALLEY WAY NE, ATLANTA 30329
EUBANKS, WILLIAM L. 29 ACT OPH
490 PEACHTREE ST NE, ATLANTA 30308
EVANS, ALBERT L. 29 ACT GS
735 PIEDMONT AVE NE, ATLANTA 30308
EVANS, E.C. 29 ACT IM
340 BOULEVARD NE, ATLANTA 30312
EVANS, JOHN S. 29 ACT GS
735 PIEDMONT AVE NE, ATLANTA 30308
FACKLER, CARL D. 29 ACT ORS
105 COLLIER RD NW STE 5000, ATLANTA 30309
FAJMAN, WILLIAM A. 29 ACT R
EMORY UNIVERSITY, ATLANTA 30322
FEINSTEIN, ARTHUR C. 29 ACT GS,ON
478 PEACHTREE ST NE, ATLANTA 30308
FELDER, LOUIS H. 29 ACT IM
35 COLLIER RD NW, ATLANTA 30309
FELDER, RICHARD E. 29 ACT P
6363 ROSWELL RD NE, ATLANTA 30328
FELICIANO, E.A. 29 ACT IM
490 PEACHTREE ST NE, ATLANTA 30308
FERGUSON, DANIEL S. 29 ACT IM
35 COLLIER RD NW STE 200, ATLANTA 30309
FERGUSON, IRA A., JR. 29 ACT GS
EMORY UNIVERSITY CLINIC, ATLANTA 30322
FERGUSON, WILSON J. 29 R GS
2000 SIX BRANCHES DR, ROSWELL 30076
FERRIER, FRANK L. 29 ACT TS
3250 HOWELL MILL RD STE 303, ATLANTA 30327
FERRIS, HAROLD A. 29 ACT IM
478 PEACHTREE ST NE, ATLANTA 30308
FIANDACA, MASSIMO S. 29 I&R NS
1073 DE LEON DR, CLARKSTON 30021
FIEDOTIN, ARNOLDD 29 ACT IM
5665 PEACHTREE DUNWOODY RD, ATLANTA 30342
FIELDER, DENNIS L. 29 ACT AN
1000 JOHNSON FERRY RD, ATLANTA 30342
FILIP, DONALD J. 29 ACT ON
105 COLLIER RD NW, ATLANTA 30309
FINCH, HENRY M. 29 R CRS

FINEGAN, ROBERT F. 29 ACT AN
2760-B FELTON DR, EAST POINT 30344
FINLAYSON, DONALD C. 29 ACT AN
1365 CLIFTON RD, ATLANTA 30322
FINNERTY, DDNALD P. 29 ACT U
PO BOX 26104, ATLANTA 30335
FINUCANE, BRENDAN 29 ACT AN
69 BUTLER ST SE, ATLANTA 30303
FISHER, J. EDWARD 29 ACT OBG
340 BOULEVARD NE, ATLANTA 30312
FISHER, WILLIAM R. 29 ACT OTO
490 PEACHTREE ST STE 265-C, ATLANTA 30308
FITZHUGH, F.W., JR. 29 ACT IM
1938 PEACHTREE RD NW, ATLANTA 30309
FITZPATRICK, PAUL E. 29 ACT IM
6185 JONESBORO RD, MORROW 30260
FLEMING, LAMAR L. 29 ACT ORS
1365 CLIFTON RD NE, ATLANTA 30322
FLETCHER, GERALD F. 29 ACT IM
300 BOULEVARD NE, ATLANTA 30312
FLINCHUM, DARIUS 29 ACT ORS
340 BOULEVARD NE STE 540, ATLANTA 30312
FLORENCE, THOMAS J. 29 ACT U
2550 WINDY HILL RD, MARIETTA 30062
FLYTHE, CARDL W. 29 ACT AN
80 BUTLER ST, ATLANTA 30303

FOEGE, WILLIAM H. 29 S
1600 CLIFTON RD NE, ATLANTA 30333
FORESTNER, JOHN E. 29 ACT AN
HENRIETTA EGLESTON HOSP, ATLANTA 30322
FORSYTH, DOUGLAS H. 29 ACT IM
993 JOHNSON FERRY RD NE, ATLANTA 30342
FOSTER, GILBERT J., JR. 29 ACT U
490 PEACHTREE ST STE 578-C, ATLANTA 30308
FOWLER, C. DIXON 29 ACT PD
27 EIGHTH ST NE, ATLANTA 30309
FOWLER, MAJOR F. 29 ACT U
2949 CARRIAGE DR, S DAYTONA FL 32019
FRADKIN, MAURY L. 29 ACT OBG
5675 PEACHTREE-DUNWOODY RD, ATLANTA 30342
FRANCH, ROBERT H. 29 ACT IM
1365 CLIFTON RD NE, ATLANTA 30322
FRANCO, NED M. 29 ACT U
960 JOHNSON FERRY RD NE, ATLANTA 30342
FRANCO, RAMON S. 29 ACT OTO
993-D JOHNSON FERRY RD, ATLANTA 30342
FRANCO, RICHARD D. 29 ACT N
993-F JOHNSON FERRY RD NE, ATLANTA 30342
FRANK, MILTON, III 29 ACT CD,IM
1372 PEACHTREE ST NE STE 301, ATLANTA 30309
FRANKLIN, ERNEST W. 29 ACT GYN
5669 PEACHTREE-DUNWOODY RD, ATLANTA 30342
FRANKLIN, REGINALD K. 29 A IM
384 PEACHTREE ST STE 1101, ATLANTA 30308
FRAZIER, WESLEY T. 29 ACT AN
EMORY UNIVERSITY HOSPITAL, ATLANTA 30322
FREDERICKSON, EVAN L. 29 ACT AN
EMORY UNIVERSITY, ATLANTA 30322
FREEDMAN, ALAN I. 29 ACT AN
35 COLLIER RD NW STE 560, ATLANTA 30309
FREEDMAN, MILTON H. 29 ACT IM
340 BOULEVARD NE, ATLANTA 30312
FREEMAN, MALCOLM G. 29 ACT OBG
69 BUTLER ST SE, ATLANTA 30303
FRIEDEWALD, WILLIAM F. 29 R IM
28 VERNON GLENN CT, ATLANTA 30338
FULENWIDER, J. TIMOTHY 29 ACT GS
1365 CLIFTON RD, ATLANTA 30322
FULGHUM, C.B., JR. 29 ACT P
1970 CLIFF VALLEY WAY NE, ATLANTA 30329
FULMER, THOMAS E. 29 ACT P
1711 UPPER GATE DR NE, ATLANTA 30307
FUNK, F. JAMES, JR. 29 ACT ORS
105 COLLIER RD NW, ATLANTA 30309
FUNK, SIDNEY A. 29 ACT OBG
5675 PEACHTREE-DUNWOODY RD, ATLANTA 30342
GABLE, THOMAS W. 29 ACT P
3400 PEACHTREE RD NE, ATLANTA 30326
GABLER, REGINA 29 ACT OBG
20 LINDEN AVE NE, ATLANTA 30365
GALAMBDS, JDHN T. 29 ACT GE
EMORY UNIVERSITY CLINIC, ATLANTA 30322
GALINA, MORTON P. 29 ACT A
993-D JOHNSON FERRY RD NE, ATLANTA 30342
GALLDWAY, WILLIAM H. 29 ACT OBG
5675 PEACHTREE-DUNWOODY RD, ATLANTA 30342
GALVIN, WILLIAM H. 29 ACT AN
231 GARDEN LN, DECATUR 30030
GAMBRELL, W. ELIZABETH 29 ACT IM
217 WILTON DR, DECATUR 30030
GAMWELL, JOHN W. 29 ACT ORS
25 PRESCOTT ST NE, ATLANTA 30308
GARCIA, ALFREDO G. 29 ACT GP
1311 EAST CLEVELAND AVE, EAST POINT 30344
GARCIA, CASIMIRO S. 29 ACT OBG
340 BOULEVARD NE, ATLANTA 30312
GARCIA, P.F. 29 ACT P
3280 HOWELL MILL RD #202, ATLANTA 30327
GARCIA-SAUL, JDSE A. 29 ACT OBG
993-D JOHNSON FERRY RD #300, ATLANTA 30329
GARNER, RDBERT C. 29 ACT PD
47 PEACHTREE PARK DR NE, ATLANTA 30309

GARNER, T. KIRKLAND 29 ACT IM
35 COLLIER RD STE 650, ATLANTA 30309
GARRETT, JOHN C. 29 ACT ORS
105 COLLIER RD NW STE 5000, ATLANTA 30309
GAY, BRIT B., JR. 29 ACT PDR
1405 CLIFTON RD NE, ATLANTA 30322
GECKLER, JOHN H. 29 R AN
1731 TRAPNELL CT, ATLANTA 30338
GEDNEY, LEIGH M. 29 S IM
3900 CROWN RD, ATLANTA 30304
GEER, BRUCE R. 29 ACT GE
3250 HOWELL MILL RD NW #200, ATLANTA 30327
GERSHON, CHARLES R. 29 ACT U
340 BOULEVARD NE STE 618, ATLANTA 30312
GERSHON, NATHAN I. 29 ACT OTO
315 BOULEVARD NE, ATLANTA 30312
GERTLER, PHILLIP E. 29 R IM
1756 FRIAR TUCK RD NE, ATLANTA 30309
GHANI, GHALEB A. 29 ACT AN
1365 CLIFTON RD NE, ATLANTA 30322
GHOLSON, A.R. 29 ACT AN
775 KINLOCH NW, ATLANTA 30327
GIBSON, SAM T. 29 A IM
8800 ROCKVILLE PIKE, BETHESDA MD 20205
GILBERT, ROBERT W., JR. 29 ACT N
105 COLLIER RD STE 2020, ATLANTA 30309
GILES, BEN J. 29 ACT AN
353 PARKWAY DR NE, ATLANTA 30312
GILLESPIE, EUGENE J. 29 R D
4525 EAST KINGS POINT CIR NE, ATLANTA 30338
GILLESPIE, ROBERT H. 29 R OBG
2115 LENOX RD NE, ATLANTA 30324
GILNER, DONALD M. 29 ACT A
960 JOHNSON FERRY RD, ATLANTA 30342
GIRARDEAU, JOSEPH L. 29 ACT OBG
105 COLLIER RD NW STE 2030, ATLANTA 30309
GLADSON, JAMES E. 29 S IM
37 WILLOWICK CT, DECATUR 30034
GLASS, LAMAR F. 29 R GS
3180 PALISADES CT, MARIETTA 30067
GLAVEY, CHRISTINE P. 29 ACT D
6500 VERNON WOODS DR NE, ATLANTA 30328
GLENN, WADLEY R. 29 ACT GS
35 LINDEN AVE NE, ATLANTA 30308
GLISSON, C. STEADMAN 29 ACT OBG
20 LINDEN AVE NE STE 7-C, ATLANTA 30365
GOBER, H. FRED 29 ACT OBG
960 JOHNSON FERRY RD NE, ATLANTA 30342
GODWIN, JOHN T. 29 ACT PTH
4691 SENTINEL POST RD NW, ATLANTA 30327
GOETZINGER, ROBERT T. 29 ACT OPH
425 FOREST PKY, FOREST PARK 30050
GOLD, PERRY 29 A PD
UNIV PLAZA SE/HLTH SVC DPT, ATLANTA 30303
GOLDEN, TERRY D. 29 ACT IM
2045 PEACHTREE RD, ATLANTA 30309
GOLDKLANG, GERALD A. 29 ACT IM,HEM
5669 PEACHTREE-DUNWOODY RD, ATLANTA 30342
GOLDMAN, ALAN L. 29 ACT GS
11050 CRABAPPLE RD, ROSWELL 30075
GOLDMAN, GILBERT C. 29 ACT D
993-D JOHNSON FERRY RD NE, ATLANTA 30309
GOLDMAN, JOHN A. 29 ACT IM
960 JOHNSON FERRY RD, ATLANTA 30342
GOLDMAN, ROBERT P. 29 ACT OBG
2788 BAYARD ST STE 201, EAST POINT 30344
GOLDMAN, STEPHEN R. 29 ACT OBG
1938 PEACHTREE RD NW STE 306, ATLANTA 30367
GOLDSTEIN, GORDON T. 29 ACT DR
1170 CLEVELAND AVE, EAST POINT 30344
GOLDSTEIN, ROBERT W. 29 ACT IM
340 BOULEVARD NE STE 214, ATLANTA 30312
GOMEZ, FRANK 29 ACT GS
195 UPPER RIVERDALE RD, RIVERDALE 30274
GOMEZ, JULIAN R. 29 ACT P
3280 HOWELL MILL RD STE 236, ATLANTA 30327
GONZALEZ, ANGELO 29 ACT GS
2741 BAYARD ST, EAST POINT 30344
GOODHART, GLENN L. 29 ACT ID
960 JOHNSON FERRY RD STE 243, ATLANTA 30342
GORDON, J. NICHOLAS 29 ACT OS
3228 HOLLY MILL RUN, MARIETTA 30062
GORDON, LOURDES N. 29 ACT AN
1681 TILLING WAY, STONE MOUNTAIN 30087
GORDON, STEPHEN F. 29 ACT OBG
960 JOHNSON FERRY RD NE, ATLANTA 30342
GORDON, STEPHEN W. 29 A PS
5440 ORLEY TERR, COLLEGE PARK 30349
GOWER, WILLIAM J. 29 ACT IM
6500 VERNON WOODS DR STE A-2, ATLANTA 30328
GRABLOWSKY, OSCAR M. 29 ACT CRS
315 BOULEVARD NE STE 220, ATLANTA 30312
GRADY, DONALD F. 29 ACT NS
993-F JOHNSON FERRY RD, ATLANTA 30342
GRADY, EDGAR D. 29 ACT GS,ND
181-A UPPER RIVERDALE RD, RIVERDALE 30274
GRAHAM, SAM D. 29 ACT U
1365 CLIFTON RD NE, ATLANTA 30322
GRAVANIS, MICHAEL B. 29 ACT PTH
EMORY UNIV SCH OF MEDICINE, ATLANTA 30322
GRAVES, RAPHAEL K. 29 ACT PTH
1000 JOHNSON FERRY RD NE, ATLANTA 30345
GREEN, BRUCE G. 29 ACT U
6500 VERNON WOODS DR NE, ATLANTA 30328
GREEN, EDMOND W. 29 ACT FP
3383 STEWART AVE, HAPEVILLE 30354
GREENBERG, IRVING L. 29 ACT GS
29 LINDEN AVE NUE STE 20-A, ATLANTA 30365
GREENBERG, JOEL I. 29 ACT OBG
2550 WINDY HILL RD STE 206, MARIETTA 30067
GREENE, DAVID 29 ACT DR
35 LINDEN AVE, ATLANTA 30308
GREGORY, HUGH H. 29 ACT GS
735 PIEDMONT AVE NE, ATLANTA 30365
GRIFFIN, BASIL M., JR. 29 ACT ORS
993 JOHNSON FERRY RD NE, ATLANTA 30342
GRIFFIN, EDMOND I. 29 ACT D
5669 PEACHTREE DUNWOODY RD, ATLANTA 30342
GRIFFIN, JOHN M. 29 ACT PS
3280 HOWELL MILL RD STE 111, ATLANTA 30327
GRIMES, W.H., JR. 29 ACT OBG
5675 PEACHTREE-DUNWOODY RD, ATLANTA 30342
GRINDON, ALFRED J. 29 ACT BLB,PTH
1925 MONROE DR NE, ATLANTA 30324
GRIST, WILLIAM J. 29 ACT OTO,HNS
1365 CLIFTON RD, ATLANTA 30322
GROSS, GAIL K. 29 ACT OBG
5675 PEACHTREE DUNWOODY RD, ATLANTA 30342
GROSS, LEON R. 29 ACT OPH
490 PEACHTREE ST STE 365-C, ATLANTA 30308
GROSS, PETER R. 29 ACT IM
384 PEACHTREE ST NE, ATLANTA 30308
GROSSMAN, GILBERT D. 29 ACT IM
25 PRESCOTT ST NE, ATLANTA 30308
GRUENTZIG, ANDREAS R. 29 ACT CD
1364 CLIFTON RD NE, ATLANTA 30322
GRUMET, ROSS R. 29 ACT P
300 BOULEVARD NE, ATLANTA 30312
GUDE, A.V. 29 ACT AN
29 MOORGATE SQUARE NW, ATLANTA 30327
GUFFIN, THOMAS N. 29 ACT GS
461 KING ARNOLD ST, HAPEVILLE 30354
GULLETT, CHARLES C. 29 ACT AM
PO BOX 20787, ATLANTA 30320
GUSSACK, HAROLD A. 29 ACT IM
478 PEACHTREE ST NE, ATLANTA 30309
GUYTON, ROBERT A. 29 ACT TS
25 PRESCOTT ST NE, ATLANTA 30308
HABER, JEROLD A. 29 ACT ORS
5667 PEACHTREE DUNWOODY RD, ATLANTA 30342
HABERMAN, MICHAEL A. 29 ACT P
3280 HOWELL MILL RD STE 230, ATLANTA 30327
HACKER, MORTIMER 29 S GP
80 TENTH ST NE, ATLANTA 30309
HACKNEY, J.F. 29 ACT PH
1611 MILL ACRES DR SW, ATLANTA 30311
HAGLER, ABIGAIL 29 I&R IM
669 DURANT PL, ATLANTA 30308
HAGLER, WILLIAM S. 29 ACT OPH
2004 PEACHTREE RD NW, ATLANTA 30309
HAILEY, CHENAULT W. 29 ACT D
478 PEACHTREE ST NE, ATLANTA 30308
HALL, H. LEE 29 ACT P
1970 CLIFF VALLEY WAY NE, ATLANTA 30329
HALL, JOHN C. 29 ACT IM
960 JOHNSON FERRY RD NE, ATLANTA 30342
HALLMAN, B.L. 29 A IM
69 BUTLER ST SE, ATLANTA 30303
HALLMAN, HELEN W. 29 R AN
RTE 2 BOX 686, REMLAP AL 35133
HALLUM, ALTON V. 29 ACT OPH
3280 HOWELL MILL RD NW #207, ATLANTA 30327
HALPER, ROBERT M. 29 ACT DR
35 COLLIER RD NW STE 305, ATLANTA 30309
HALTIWANGER, EARL 29 S U
1670 CLAIRMONT RD NE, DECATUR 30033
HAMFF, L. HARVEY 29 ACT IM
478 PEACHTREE ST NE, ATLANTA 30308
HAMM, WILLIAM G. 29 ACT PS
3280 HOWELL MILL RD NW, ATLANTA 30327
HAMMAD, W. DAVID 29 ACT PD
315 BOULEVARD NE STE 428, ATLANTA 30312
HAMMONDS, WILLIAM D. 29 ACT AN
1365 CLIFTON RD NE, ATLANTA 30322
HANCOCK, CHARLES I. 29 ACT ORS
315 BOULEVARD NE STE 312, ATLANTA 30312
HANCOCK, ROBERT K. 29 ACT OBG
490 PEACHTREE ST NE, ATLANTA 30308
HANDELSMAN, STUART 29 ACT IM
960 JOHNSON FERRY RD NE, ATLANTA 30342
HANES, O. EUGENE 29 ACT IM
2315 LIFE OF GEORGIA TOWER, ATLANTA 30308
HANKEY, DANIEL D. 29 R IM
490 PEACHTREE ST NE, ATLANTA 30308
HANSEN, ROBERT F. 29 S PH
2 EMMA LN NE, ATLANTA 30305
HANZLICK, RANDY L. 29 ACT FOP
50 COCA COLA PL SE, ATLANTA 30303
HARBIN, THOMAS S., JR. 29 ACT OPH
2004 PEACHTREE RD NW, ATLANTA 30309
HARDIN, FREDERICK F. 29 ACT D
105 COLLIER RD NW STE 4070, ATLANTA 30309
HARDISON, JOSEPH E. 29 S IM
1670 CLAIRMONT RD, DECATUR 30033
HARDMAN, JOHN B. 29 ACT CHP
2151 PEACHFORD RD, ATLANTA 30338
HARPER, BYRON F., JR. 29 ACT IM
2739 BAYARD ST, EAST POINT 30344
HARPER, JOHN T. 29 ACT ORS
340 BOULEVARD NE STE 608, ATLANTA 30312
HARPER, WILLIAM N. 29 ACT IM
75 PIEDMONT AVE NE, ATLANTA 30303
HARRIS, BOAZ 29 ACT P
3280 HOWELL MILL RD STE 338, ATLANTA 30327
HARRIS, J. FRANK 29 ACT IM
384 PEACHTREE ST NE, ATLANTA 30308
HARRIS, JAMES B. 29 ACT OBG
210 AUBURN AVE NE STE 6, ATLANTA 30303
HARRISON, CHARLES E., JR. 29 ACT IM
35 COLLIER RD NW STE 350, ATLANTA 30309
HARRISON, EUGENE O. 29 ACT GS
340 BOULEVARD NE, ATLANTA 30312
HARRISON, J.HAROLD 29 ACT CD
490 PEACHTREE ST NE, ATLANTA 30308
HARTLEY, JOHN H., JR. 29 ACT PS
3280 HOWELL MILL RD STE 111, ATLANTA 30327
HARTRAMPF, CARL R., JR. 29 ACT PS
993-C JOHNSON FERRY RD NE, ATLANTA 30342

HARVEY, JOHN S. 29 ACT GS
960 JOHNSON FERRY RD NE, ATLANTA 30342
HARWODD, ROBERT A. 29 ACT DR
1000 JOHNSON FERRY RD NE, ATLANTA 30338
HASTY, LEWIS B. 29 ACT OBG
1702 CLEVELAND AVE, EAST POINT 30344
HATCHER, CHARLES R. 29 ACT GS
EMORY UNIVERSITY CLINIC, ATLANTA 30322
HATCHER, ROBERT A. 29 A
393 WEST WESLEY RD NW, ATLANTA 30305
HATHCOCK, WILLIAM C. 29 ACT OTO
401 PEACHTREE ST NE, ATLANTA 30308
HAUCK, A.E. 29 ACT GS
478 PEACHTREE ST NE, ATLANTA 30308
HAUN, CDSMD L. 29 ACT R
EMORY UNIVERSITY CLINIC, ATLANTA 30322
HAVERTY, J. RHODES 29 ACT PD
33 GILMER ST, ATLANTA 30303
HAWK, JUDSON L., JR. 29 ACT PD
1001 JOHNSON FERRY RD NE, ATLANTA 30363
HAYNES, RALPH L. 29 ACT PUD
250 RIVERWOOD CT, ATLANTA 30328
HEARIN, DAVID L. 29 ACT D
3158 MAPLE DR NE, ATLANTA 30305
HEATH, TIM RAY 29 ACT GS
3280 HOWELL MILL RD STE 327, ATLANTA 30327
HECHT, HOWARD L. 29 ACT ORS
5667 PEACHTREE-DUNWOODY RD, ATLANTA 30342
HEGE, DARVIN 29 ACT P
2150 PEACHFORD RD STE H, ATLANTA 30338
HEILMAN, RICHARD B. 29 ACT OM
PO BOX 49447, ATLANTA 30359
HEIN, DAVID E. 29 ACT IM
340 BOULEVARD NE, ATLANTA 30312
HELMS, WILLIAM C. 29 ACT OBG
35 COLLIER RD NW, ATLANTA 30309
HENDEE, ARMAND E. 29 ACT OBG
EMORY UNIVERSITY CLINIC, ATLANTA 30322
HENDERSON, CHARLES A. 29 ACT ON
105 COLLIER RD NW, ATLANTA 30309
HENDLEY, ROBERT L. 29 ACT OPH
11050 CRABAPPLE RD STE 107, ROSWELL 30075
HENDRIX, VERNON J. 29 ACT OBG
960 JOHNSON FERRY RD NE, ATLANTA 30342
HENNESSY, DANIEL J. 29 ACT OPH
3280 HOWELL MILL RD STE 124, ATLANTA 30327
HENRY, J. LAMDNT 29 ACT IM
650 MOORES MILL RD #4, ATLANTA 30327
HERD, PAUL A. 29 ACT IM
35 COLLIER RD NW, ATLANTA 30309
HERNANDEZ, R.J. 29 ACT AN
353 PARKWAY DR NE, ATLANTA 30312
HERNDON, E. GARLAND, JR. 29 ACT IM
1440 CLIFTON RD NE, ATLANTA 30322
HERSH, THEODORE 29 ACT GE
1365 CLIFTON RD NE, ATLANTA 30322
HERSKOWITZ, LDUIS J. 29 ACT D,IM
4555 NORTH SHALLOWFORD RD, ATLANTA 30338
HESTER, T. RDDERICK, JR. 29 ACT PS
1365 CLIFTON RD NE, ATLANTA 30322
HEWELL, GUY C. 29 ACT OBG
1123 BERKSHIRE RD NE, ATLANTA 30306
HILL, EUGENE A. 29 ACT OBG
5667 PEACHTREE-DUNWOODY RD, ATLANTA 30342
HILL, JULIUS N., III 29 ACT AN
353 PARKWAY DR NE, ATLANTA 30312
HILL, WALTER JAMES 29 A P
1293 PEACHTREE ST NE, ATLANTA 30309
HILL, WILLIAM H. 29 ACT GS
3280 HOWELL MILL RD NW 201, ATLANTA 30327
HILLIARD, KATHARINE A. 29 I&R P
1884 RIDGEWOOD DR NE, ATLANTA 30307
HILLIARD, KATHARINE A. 29 I&R P
1884 RIDGEWOOD DR NE, ATLANTA 30307
HILSMAN, J.H. 29 ACT IM
35 COLLIER RD NW, ATLANTA 30309
HINKLE, JAMES E. 29 ACT AN
4575 NORTH SHALLOWFORD RD, CHAMBLEE 30342
HINSON, WARREN A. 29 ACT P
5064 ROSWELL RD NE, ATLANTA 30342
HIRSH, EUGENE H. 29 ACT IM,GE
3280 HOWELL MILL RD STE 103, ATLANTA 30327
HIRT, ALFREDD 29 ACT U
490 PEACHTREE ST NE, ATLANTA 30308
HOBBY, LOVIC W. 29 ACT PS
35 COLLIER RD NW, ATLANTA 30309
HDFFMAN, BYRDN J. 29 ACT IM
768 JUNIPER ST NE, ATLANTA 30308
HDFFMAN, JAMES C., JR. 29 ACT R
1365 CLIFTON RD NE, ATLANTA 30322
HDFFMAN, JDSEPH I., JR. 29 ACT ORS
2945 STONE HOGAN RD CONN SW, ATLANTA 30331
HOLLAND, BERNARD C. 29 ACT P
1711 UPPERGATE DR NE, ATLANTA 30322
HOLLOWAY, CHARLES E. 29 ACT GS
478 PEACHTREE ST NE, ATLANTA 30308
HOLLOWAY, GEORGE A., JR. 29 ACT AN
1968 PEACHTREE RD NW, ATLANTA 30309
HDLMES, HAMILTON E. 29 ACT ORS
340 BOULEVARD NE, ATLANTA 30312
HOMLAR, MARJORIE 29 ACT FP
6500 VERNON WOODS DR ' C-23, ATLANTA 30328
HDOPER, DDNALD 29 ACT AN
145 15TH ST #1401, ATLANTA 30309
HOPKINS, CHARLES T., JR. 29 I&R ORS
80 BUTLER ST, ATLANTA 30303
HDPKINS, L.C., JR. 29 ACT N
1365 CLIFTON RD NE, ATLANTA 30322
HOPKINS, WILLIAM A. 29 R GS
5669 PEACHTREE-DUNWOODY RD, ATLANTA 30342
HORNBERGER, R.B. 29 ACT PTH
340 BOULEVARD NE, ATLANTA 30312
HDRNEY, JDHN T. 29 ACT IM
3250 HOWELL MILL RD NW, ATLANTA 30327
HOTALEN, WILLIAM B. 29 ACT OM
4 WOODLAWN DR, MARIETTA 30067
HDTCHKISS, RICHARD S. 29 I&R IM
6 WHITTIER PL APT 4-C, BOSTON MA 02114
HOUSER, FRANK M., JR. 29 ACT PD
3280 HOWELL MILL RD, ATLANTA 30327
HOWARD, CHARLES K. 29 ACT PH
5084 NORTH PEACHTREE RD, ATLANTA 30338
HDWARD, JAMES A. 29 ACT P
960 JOHNSON FERRY RD NW, ATLANTA 30342
HDWELL, BARBARA P. 29 ACT OM
620 PEACHTREE ST NE, ATLANTA 30365
HOWELL, TOM S., JR. 29 ACT GS
620 PEACHTREE ST NE, ATLANTA 30308
HDWLAND, W. SLDCUM, JR. 29 ACT ORS
3250 HOWELL MILL RD NW, ATLANTA 30327
HUBBARD, DDNALD E. 29 ACT OBG
35 COLLIER RD NW, ATLANTA 30309
HUG, CARL C., JR. 29 ACT AN
1364 CLIFTON RD NE, ATLANTA 30322
HUGER, WILLIAM, JR. 29 ACT PS
35 COLLIER RD NW, ATLANTA 30309
HUGHES, JDE L. 29 ACT ORS
1311 CLEVELAND AVE, EAST POINT 30344
HUGULEY, CHARLES M., JR. 29 ACT IM
1365 CLIFTON RD NE, ATLANTA 30322
HUIE, RALPH A., JR. 29 ACT IM
3415 ASHWOOD LN, CHAMBLEE 30341
HUMPHREYS, JDHN L. 29 ACT OPH
615 PEACHTREE ST NE, ATLANTA 30308
HUNTER, CONWAY W., JR. 29 ACT OBG
4555 NORTH SHALLOWFORD RD, ATLANTA 30338
HUNTER, LETHA Y. 29 ACT ORS
105 COLLIER RD NW STE 5000, ATLANTA 30367
HUPMAN, AARON J. 29 ACT D
354 ARCADO RD STE 2, LILBURN 30247
HURD, RICHARD A., JR. 29 ACT ORS
4536 CHAMBLEE-DUNWOODY RD NE, ATLANTA 30338
HURST, J. WILLIS 29 ACT IM
69 BUTLER ST SE, ATLANTA 30303
HUTCHINSON, J.R.B. 29 ACT OTO,A
1462 MONTREAL RD STE 403, TUCKER 30084
HUTTD, MARK C. 29 ACT P
2150 PEACHFORD RD STE B, ATLANTA 30338
HYDRICK, PETER 29 ACT OBG
1100 CLEVELAND AVE 201, EAST POINT 30344
HYERS, JOHN J. 29 ACT AN
35 COLLIER RD NW STE 560, ATLANTA 30309
ISAACSON, IRA 29 ACT AN
1364 CLIFTON RD NE, ATLANTA 30322
ISENBERG, SIDNEY 29 ACT P
44 25TH ST NW, ATLANTA 30309
IVEY, JOHN C. 29 ACT GS
PO BOX 399, MEANSVILLE 30256
JACKSON, ZACH W. 29 ACT OPH
2911 PHARR CT S #906, ATLANTA 30305
JACDBS, JOHN L. 29 ACT A
2883 ANDREWS DR NW, ATLANTA 30305
JACOBS, JULIAN 29 S IM
1670 CLAIRMONT RD, DECATUR 30033
JACDBSDN, DAVID J. 29 ACT OBG
993 JOHNSON FERRY RD NE, ATLANTA 30342
JAEGER-LEE, DDROTHY S. 29 R PD,CHP
3458 ROXBORO RD NE, ATLANTA 30326
JAFFE, STEVEN L. 29 ACT P,CHP
6667 VERNON WOODS DR NE, ATLANTA 30328
JAMES, W. SCOTT 29 ACT PD
993-D JOHNSON FERRY RD NE, ATLANTA 30342
JANKO, GARY S. 29 ACT
5667 PEACHTREE DUNWOODY RD, ATLANTA 30342
JARMAN, JULIAN A. 29 S GS
1670 CLAIRMONT RD, DECATUR 30033
JARRETT, WILLIAM H. 29 ACT OPH
2004 PEACHTREE RD NW, ATLANTA 30309
JARVIS, JACK R. 29 S P
1670 CLAIRMONT RD, DECATUR 30333
JERKINS, GREGORY LEE 29 I&R
300 BOULEVARD NE, ATLANTA 30312
JDEL, CHARLES, JR. 29 S N
4540 RUNNEMEDE RD NW, ATLANTA 30327
JOFFE, ALAN L. 29 ACT OBG
1175 PEACHTREE ST NE, ATLANTA 30361
JOHNS, R. ALLEN, II 29 ACT AN
35 COLLIER RD NE STE 560, ATLANTA 30309
JDHNSDN, CHARLES E. 29 ACT IM
3250 HOWELL MILL RD NE, ATLANTA 30327
JOHNSON, HENRY C., JR. 29 ACT R
35 COLLIER RD NW, ATLANTA 30309
JOHNSON, L. MALCOLM 29 ACT OM
3580 ATLANTA AVE, HAPEVILLE 30354
JOHNSON, MARY M. 29 ACT NS
5675 PEACHTREE-DUNWOODY RD, ATLANTA 30342
JOHNSON, MCCLAREN 29 ACT GE
5594 CORONATION CT NE, ATLANTA 30338
JOHNSON, R. JULIAN 29 ACT IM
5667 PEACHTREE DUNWOODY RD, ATLANTA 30342
JDHNSDN, RAY L. 29 ACT P
478 PEACHTREE ST STE 909-A, ATLANTA 30308
JOHNSON, RICHARD H. 29 ACT IM
2045 PEACHTREE RD NE, ATLANTA 30309
JOHNSON, STEVEN D. 29 ACT IM,EM
339 ELMIRA PL, ATLANTA 30307
JOHNSTON, JANICE W. 29 ACT OBG
1938 PEACHTREE RD STE 101, ATLANTA 30309
JONES, ARTHUR B., JR. 29 ACT OBG
384 PEACHTREE ST NE, ATLANTA 30308
JONES, CARL C., JR. 29 ACT A
3316 PIEDMONT RD, ATLANTA 30305
JONES, E. LADD, JR. 29 ACT ORS
3250 HOWELL MILL RD NW, ATLANTA 30327
JONES, ELLIS L. 29 ACT TS
1365 CLIFTON RD NE, ATLANTA 30322
JONES, GEDRGE W., JR. 29 ACT IM
490 PEACHTREE ST NE, ATLANTA 30308

JONES, LEWIS E. 29 R IM
1752 MORRIS LANDERS DR NE, ATLANTA 30345
JONES, NORMAN E. 29 ACT TR
1968 PEACHTREE RD NW, ATLANTA 30309
JONES, RICHARD B. 29 ACT IM
6500 VERNON WOODS DR NE, ATLANTA 30328
JORDAN, W. DAN 29 ACT GS
35 COLLIER RD NW, ATLANTA 30309
JOSEPH, ALFRED 29 ACT PD
777 CLEVELAND AVE SW, ATLANTA 30315
JOSEPH, FRANK R. 29 ACT HS
3280 HOWELL MILL RD NW, ATLANTA 30327
JOSEPHS, ALVIN D. 29 R IM
1670 CLAIRMONT RD, DECATUR 30033
JOSEY, WILLIAM E. 29 ACT OBG
1365 CLIFTON RD NE, ATLANTA 30322
JOVE, DONNA F. 29 ACT PTH
1216 ARBOR VISTA DR NE, ATLANTA 30329
JURKIEWICZ, MAURICE J. 29 ACT PS
1365 CLIFTON RD NE, ATLANTA 30322
KAHLE, DAN BRUCE 29 ACT OBG
960 JOHNSON FERRY RD NE, ATLANTA 30342
KAHN, ERIC M. 29 ACT CDS
993-F JOHNSON FERRY RD NE, ATLANTA 30342
KAHN, S. DAVID 29 ACT P
3400 PEACHTREE RD NE, ATLANTA 30326
KAPLAN, RONALD I. 29 ACT GS
2550 WINDY HILL RD STE 202, MARIETTA 30067
KARASU, SUAT 29 ACT AN
4845 JETT RD NW, ATLANTA 30327
KARP, HERBERT R. 29 ACT N
1817 CLIFTON RD NE, ATLANTA 30029
KARPAS, ANTHONY E. 29 ACT END
478 PEACHTREE ST NE, ATLANTA 30308
KASSAM, GULZAR B. 29 ACT OBG
478 PEACHTREE ST NE, ATLANTA 30308
KAUFMANN, GARY E. 29 ACT NS
2550 WINDY HILL RD STE 110, MARIETTA 30067
KAUFMANN, JAMES A. 29 ACT IM
565 WEST PEACHTREE ST NE, ATLANTA 30308
KELLEHER, ROBERT M. 29 ACT D
4536 CHAMBLEE DUNWOODY RD, ATLANTA 30338
KELLER, JAMES W. 29 ACT ON
1365 CLIFTON RD NE, ATLANTA 30322
KELLY, JAMES D. 29 R GS
3113 LENOX RD, ATLANTA 30324
KELMAN, LESLIE 29 ACT N
993-F JOHNSON FERRY RD NE, ATLANTA 30342
KEMPER, CLIFTON G. 29 ACT FP
956 STOVALL BLVD NE, ATLANTA 30319
KENNY, WILLIAM R. 29 ACT PUD
1968 PEACHTREE ROAD, ATLANTA 30309
KIBLER, ROBERT F. 29 ACT IM
1365 CLIFTON RD NE, ATLANTA 30322
KILEY, JAMES D. 29 ACT IM
3250 HOWELL MILL RD NE, ATLANTA 30327
KILPATRICK, WILLIAM H. 29 ACT OBG
1311 CLEVELAND AVE, EAST POINT 30344
KIM, H. HAHK 29 ACT PDS
315 BOULEVARD NE STE 332, ATLANTA 30312
KIM, JONG-IN 29 ACT AN
2760-B FELTON DR, EAST POINT 30344
KIM, SUN-HEE 29 ACT GS
2351 BOLTON RD NW, ATLANTA 30318
KING, J. DUDLEY 29 ACT R
35 LINDEN AVE NE, ATLANTA 30365
KING, JAMES T. 29 ACT OTO
1890 WEST PACES FERRY RD, ATLANTA 30327
KING, RICHARD 29 ACT TS
35 COLLIER RD NW, ATLANTA 30309
KING, SPENCER B., III 29 ACT CD
EMORY UNIVERSITY CLINIC, ATLANTA 30322
KING, STEPHEN 29 ACT PD
6667 VERNON WOODS DR NE, ATLANTA 30328
KINGLOFF, DANIEL L. 29 ACT ORS
490 PEACHTREE ST NE, ATLANTA 30308
KIRCHNER, ARTHUR B. 29 ACT R
5665 PEACHTREE-DUNWOODY RD, ATLANTA 30342
KISER, ELLEN F. 29 ACT P
2637 PEACHTREE RD NE #205, ATLANTA 30305
KITE, J.H. 29 ACT ORS
10151 GOLF CLUB DR, JACKSONVILLE, FL 32216
KLEIN, LUELLA M. 29 ACT OBG
25 PRESCOTT ST NE, ATLANTA 30308
KLERIS, GEORGE S. 29 A PH
99 BUTLER ST SE, ATLANTA 30303
KLINE, RANDOLPH W. 29 ACT P
811 JUNIPER ST NE, ATLANTA 30308
KLOPMAN, ALEX Z. 29 ACT FP
1150 GRIMES BRIDGE RD, ROSWELL 30075
KLOPPER, RALPH M. 29 ACT P
456 EAST PACES FERRY RD NE, ATLANTA 30305
KLOPSTOCK, WILLIAM J. 29 ACT P
3280 HOWELL MILL RD STE 202, ATLANTA 30327
KLOSTER, GILBERT J. 29 ACT PS
5669 PEACHTREE-DUNWOODY RD, ATLANTA 30342
KLOTZ, HUGH A. 29 ACT OPH
993-C JOHNSON FERRY RD NE, ATLANTA 30342
KNAPP, WILLIAM S. 29 ACT CD,IM
3250 HOWELL MILL RD, STE 306, ATLANTA 30327
KNOWLTON, GREGORY B. 29 ACT NEP
5669 PEACHTREE-DUNWOODY RD, ATLANTA 30342
KOBAYASHI, T. KENJI 29 ACT ORS
3890 E PONCE DE LEON AVE, CLARKSTON 30021
KOENIG, RONALD H. 29 ACT N
1680 MULKEY RD STE C, AUSTELL 30001
KOFFLER, BARRY A. 29 ACT ORS
1190 GRIMES BRIDGE RD, ROSWELL 30075
KOLLA, IRIS S. 29 I&R
2537 ECHO DR NE, ATLANTA 30345
KOLMEIER, KARL H. 29 ACT IM
4555 NORTH SHALLOWFORD RD, CHAMBLEE 30338
KOLODNER, ROBERT M. 29 S P
1670 CLAIRMONT RD, DECATUR 30033
KOORNICK, ALAN R. 29 ACT OS
5669 PEACHTREE-DUNWOODY RD, ATLANTA 30342
KORANSKY, JACK R. 29 ACT GE
993-F JOHNSON FERRY RD NE, ATLANTA 30342
KORSOWER, ALLAN J. 29 ACT NS
3280 HOWELL MILL RD NW, ATLANTA 30327
KORT, HILTON I. 29 ACT OBG
960 JOHNSON FERRY RD, ATLANTA 30342
KOZINN, MARK A. 29 ACT N
2788 BAYARD ST, EAST POINT 30344
KRAKOW, RICHARD A. 29 ACT D
11050 CRABAPPLE RD #102, ROSWELL 30075
KRAL, ROBERT A. 29 ACT OBG
1720 OLD SPRINGHOUSE LN, ATLANTA 30338
KRAMER, RUSSELL H. 29 ACT GE,IM
5667 PEACHTREE-DUNWOODY RD, ATLANTA 30342
KRISSMAN, PAUL H. 29 ACT IM
340 BOULEVARD NE #238, ATLANTA 30312
KRUGMAN, PHILIP I. 29 ACT OBG
3280 HOWELL MILL RD STE 337, ATLANTA 30327
KUPSHIK, HILTON L. 29 ACT AN
35 COLLIER RD NW STE 560, ATLANTA 30309
KURTZ, JOSEPH L. 29 ACT ORS
2635 BROOKDALE DR NW, ATLANTA 30305
KUTNER, STEPHEN S. 29 ACT OPH
353 PARKWAY DR NE, ATLANTA 30312
LACKEY, DIXON A. 29 ACT PH
440 OLD CREEK RD NE, ATLANTA 30342
LAHMAN, ROSE A. 29 ACT GYN
1234 POWERS FERRY RD ' 102, MARIETTA 30067
LAMAN, EDWARD N. 29 ACT AN
3030 NANCY CREEK RD, ATLANTA 30327
LAMIS, PANO A. 29 ACT GS
315 BOULEVARD NE, ATLANTA 30312
LAMPERT, SCOTT I. 29 ACT OPH
3280 HOWELL MILL RD STE 319, ATLANTA 30327
LANDY, MICHAEL S. 29 ACT IM
2739 FELTON DR, EAST POINT 30344
LANE, DONALD R. 29 ACT IM
5243 SNAPFINGER WOODS DR, DECATUR 30035
LANG, WILLIAM C., JR. 29 ACT R
3200 HOWELL MILL RD NW, ATLANTA 30327
LANGSAM, CHARLES L. 29 ACT
350 CARPENTER DR NE APT 824, ATLANTA 30328
LANIER, BOB G. 29 ACT IM
3250 HOWELL MILL RD NW, ATLANTA 30327
LANIER, WILLIS E. 29 ACT OBG
960 JOHNSON FERRY RD NE, ATLANTA 30342
LATHAM, ELIZABETH B. 29 ACT PD
2245 GODBY RD, COLLEGE PARK 30349
LATHAN, S. ROBERT 29 ACT IM
1938 PEACHTREE RD NW STE 606, ATLANTA 30309
LAUBE, JUDITH M. 29 ACT AN
705 JUNIPER ST NE, ATLANTA 30308
LAVIETES, PAUL A. 29 ACT R
35 LINDEN AVE NE, ATLANTA 30365
LAWRENCE, GEORGE C. 29 ACT OBG
75 PIEDMONT AVE NE, ATLANTA 30303
LAYNE, EDWARD A. 29 A IM,GE
2600 MLK JR DR SW, ATLANTA 30311
LEE, DENNIS E. 29 ACT ORS
993 JOHNSON FERRY RD NE, ATLANTA 30342
LEE, JOHN E. 29 ACT N
993-F JOHNSON FERRY RD NE, ATLANTA 30342
LEE, JOHN L. 29 ACT OBG
11050 CRABAPPLE RD, ROSWELL 30075
LEE, S. REAVES 29 ACT P
1493 LAVISTA RD NE, ATLANTA 30324
LEE, STEVEN R. 29 ACT P
3280 HOWELL MILL RD STE 336, ATLANTA 30327
LEFKOFF, HAROLD J. 29 ACT OTO
315 BOULEVARD NE, ATLANTA 30312
LEIGH, TED F. 29 ACT R
1803 ROCKRIDGE PL NE, ATLANTA 30324
LEONARD, JAMES R. 29 ACT OTO
3280 HOWELL MILL RD STE 333, ATLANTA 30327
LEONARD, WILLIAM P. 29 ACT GS
3406 OLD PLANTATION RD NW, ATLANTA 30327
LEONARDY, JOHN G. 29 ACT IM
478 PEACHTREE ST NE, ATLANTA 30308
LERMAN, BERNARD 29 ACT GS
3280 HOWELL MILL RD STE 241, ATLANTA 30327
LESESNE, ARTHUR E. 29 ACT IM
575 WEST PEACHTREE ST NW, ATLANTA 30308
LESSER, JOSEPH M., PH.D. 29 ACT IM
490 PEACHTREE ST STE 137-B, ATLANTA 30308
LESTER, JESS C. 29 ACT OPH
478 PEACHTREE ST NE, ATLANTA 30308
LESTER, WILLIAM M. 29 ACT OBG
5675 PEACHTREE-DUNWOODY RD, ATLANTA 30342
LETTON, A. HAMBLIN 29 ACT GS
315 BOULEVARD NE STE 500, ATLANTA 30312
LEVIN, HAROLD B. 29 ACT D
1293 PEACHTREE ST NE, ATLANTA 30309
LEVIN, JACK M. 29 ACT CRS
340 BOULEVARD NE, ATLANTA 30312
LEVINE, MARSHALL R. 29 ACT IM
2045 PEACHTREE RD NE STE 425, ATLANTA 30309
LEVINE, MICHAEL K. 29 ACT PD
6500 VERNON WOODS DR, ATLANTA 30328
LEVINE, STEPHEN B. 29 ACT OPH
5675 PEACHTREE-DUNWOODY RD, ATLANTA 30342
LEVITT, RICHARD A. 29 ACT PD
625 COLONIAL PARK DR STE 101, ROSWELL 30075
LEVY, ARTHUR J. 29 ACT TS
5667 PEACHTREE-DUNWOODY RD, ATLANTA 30342
LEVY, CHARLES E. 29 ACT P
5300 WILLOW POINT PKY, MARIETTA 30067
LEVY, LOUIS K. 29 R IM
2045 PEACHTREE RD NE, ATLANTA 30309
LEWIS, JOHN R., JR. 29 ACT PS
3316 PIEDMONT RD NE, ATLANTA 30305
LIBERMAN, HENRY A. 29 ACT IM,CD
25 PRESCOTT ST NE, ATLANTA 30308

LICHTMAN, STANLEY 29 ACT AN
2760-B FELTON DR, EAST POINT 30344
LIEPPE, WILLIAM M. 29 ACT CD
5669 PEACHTREE DUNWOODY RD, ATLANTA 30342
LIEVAND, ALVARD 29 ACT ORS
PO DRAWER T, EAST POINT 30344
LIN, HUI-CHING Y. 29 R PH
634 WILSON RD NW, ATLANTA 30318
LINDSEY, I.L. 29 ACT N
993-F JOHNSON FERRY RD NE, ATLANTA 30342
LINE, RDBIN L. 29 ACT FP
90 WEST WIEUCA RD NE, ATLANTA 30342
LIPMAN, BERNARD S. 29 ACT IM
3280 HOWELL MILL RD STE 103, ATLANTA 30327
LIPSCDMB, THOMAS L. 29 ACT OM
3580 ATLANTA AVE, HAPEVILLE 30354
LIPSITCH, IAN I. 29 ACT P
5064 ROSWELL RD NE, ATLANTA 30342
LITTLE, RICHARD R. 29 ACT AN
5665 PEACHTREE DUNWOODY RD, ATLANTA 30342
LLOYD, PATRICIA K.A. 29 ACT IM
300 BOULEVARD BOX 476, ATLANTA 30312
LOCHRIDGE, E.P., JR. 29 ACT CRS
35 COLLIER RD NW, ATLANTA 30309
LOCKRIDGE, JOHN B. 29 ACT P,CHP
5667 PEACHTREE DUNWOODY RD, ATLANTA 30342
LOFTMAN, BERT A. 29 ACT NS
105 COLLIER RD NW, ATLANTA 30309
LDGAN, WILLIAM D., JR. 29 ACT TS
272 BOULEVARD NE, ATLANTA 30312
LOGUE, R. BRUCE 29 ACT CD
25 PRESCOTT ST NE, ATLANTA 30308
LOHAUS, GERHARD H. 29 ACT IM
993-D JOHNSON FERRY RD NE, ATLANTA 30342
LOKEY, JULIAN L. 29 ACT ON
993-D JOHNSON FERRY RD NE, ATLANTA 30342
LONG, LEONARD 29 R
PO BOX 277, CASHIERS NC 28717
LDNG, WILLIAM B. 29 ACT OPH
4957 LAVISTA RD, TUCKER 30084
LOPEZ, CARLOS E. 29 ACT IM
1938 PEACHTREE RD NW STE 204, ATLANTA 30309
LOPEZ, JOSE 29 ACT AN
409 ARROWHEAD BLVD, JONESBORO 30236
LDRD, CLYDE O. 29 A AN
501 FAIRBURN RD SW, ATLANTA 30331
LDUGHLIN, EDWARD C. 29 ACT ORS
1938 PEACHTREE RD NW, ATLANTA 30309
LDWANCE, DAVID C. 29 ACT IM
35 COLLIER RD NW STE 610, ATLANTA 30309
LOWANCE, MASON I. 29 ACT A
2734 PEACHTREE RD C-204, ATLANTA 30305
LOWENBERG, RDBERT I. 29 R GS,CD
5333 LONG ISLAND DR NW, ATLANTA 30327
LUCAS, GEORGE W. 29 ACT GS
340 BOULEVARD NE, ATLANTA 30312
LUCCHESE, MARY CECILIA 29 I&R
81 WAKEFIELD DR NE, ATLANTA 30309
LUND, ROBERT W. 29 ACT IM
35 COLLIER RD NW STE 425, ATLANTA 30309
LYDN, DAVID B. 29 ACT P
2151 PEACHFORD RD, ATLANTA 30338
LYON, JAMES B. 29 ACT OBG
105 COLLIER RD NW STE 3080, ATLANTA 30309
MABON, ROBERT 29 ACT NS
3053 ANDREWS DR NW, ATLANTA 30305
MACHADO, M.D. 29 ACT AN
3830 SOUTH COBB DR STE 213, SMYRNA 30080
MACNEILL, CHARLES A. 29 ACT AN
5675 PEACHTREE DUNWOODY RD, ATLANTA 30342
MACON, PHILIP F. 29 ACT ORS
5667 PEACHTREE-DUNWOODY RD, ATLANTA 30342
MACRIS, ALLEN G. 29 ACT TS
490 PEACHTREE ST NE, ATLANTA 30308
MACWILLIAMS, PETER 29 ACT D
1001 THORNTON RD 803, LITHIA SPRINGS 30057

MAFFETT, MICHAEL E. 29 A IM
4735 WOODVALE DR NW, ATLANTA 30327
MAHAN, THDMAS P. 29 ACT AN
35 COLLIER RD NW, ATLANTA 30309
MAHDLICK, LEDNARD T. 29 ACT P
3316 PIEDMONT RD NE, ATLANTA 30326
MALLORY, JAMES D., JR. 29 ACT P
4350 GEORGETOWN SQ, ATLANTA 30338
MALONE, PATRICK T. 29 ACT P
6363 ROSWELL RD NE, ATLANTA 30328
MALDNE, VIRGINIA G. 29 DE2 IM
99 CONNEMARA RD, ROSWELL 30075
MANCHESTER, P. THOMAS, JR. 29 ACT OPH
35 COLLIER RD NW, ATLANTA 30309
MANGET, J.D., JR. 29 ACT FP
1879 GREYSTONE RD NW, ATLANTA 30318
MANI, MURUGIAH 29 ACT AN
353 PARKWAY DR NE, ATLANTA 30312
MANIS, ROBERT 29 ACT P
4167 ROSWELL RD NE, ATLANTA 30342
MANNING, DONALD E. 29 ACT P
1365 CLIFTON RD NE, ATLANTA 30322
MANNO, JOSEPH A., III 29 ACT OPH
3280 HOWELL MILL RD NW, ATLANTA 30327
MANSOUR, KAMAL A. 29 ACT TS
1365 CLIFTON RD NE, ATLANTA 30322
MARCHMAN, MARVIN L. 29 ACT FP
6185 SOUTH BUFORD HWY, NORCROSS 30071
MARCUCCI, MIGUEL A. 29 ACT CDS
4760 AUSTELL RD, AUSTELL 30001
MARGESON, RICHARD C. 29 ACT GS
1938 PEACHTREE RD NW, ATLANTA 30309
MARGOLIS, BASIL 29 ACT IM,CD
5669 PEACHTREE-DUNWOODY RD, ATLANTA 30342
MARKS, THOMAS W. 29 ACT ORS
315 BOULEVARD NE STE 400, ATLANTA 30312
MARMER, ROBERT H. 29 ACT OPH
777 CLEVELAND AVE SW, ATLANTA 30315
MARTIN, J.D., JR. 29 R GS
230 ROBIN HOOD RD NE, ATLANTA 30309
MARTIN, WILLIAM D., III 29 ACT OPH
1938 PEACHTREE RD NW, ATLANTA 30309
MASON, EDWARD M. 29 ACT GS
315 BOULEVARD NE STE 500, ATLANTA 30312
MASON, W. RDY, JR. 29 R IM
1131 SPRINGDALE RD NE, ATLANTA 30306
MASON, WILLIAM A. 29 R PH
620 PEACHTREE ST NE, ATLANTA 30308
MASSEE, JOSEPH C. 29 ACT IM
21 EIGHTH ST NE, ATLANTA 30309
MASSEY, JOE B. 29 ACT OBG
960 JOHNSON FERRY RD NE, ATLANTA 30342
MATTHEWS, SANFDRD J. 29 ACT PD
1938 PEACHTREE RD NW, ATLANTA 30309
MAUGHON, JAMES S. 29 ACT GS
300 BOULEVARD NE, ATLANTA 30312
MAULDIN, JOHN T. 29 ACT GS
1422 WEST PEACHTREE ST NW, ATLANTA 30309
MAYER, W. BREM, JR. 29 ACT N
25 PRESCOTT ST NE 4TH FLOOR, ATLANTA 30308
MAZIAR, HDWARD M. 29 ACT P
3400 PEACHTREE RD STE 1211, ATLANTA 30326
MAZUR, W.P. 29 ACT P
490 PEACHTREE ST STE 101-C, ATLANTA 30308
MCALISTER, RDBERT E. 29 ACT FP,OM
5635 PEACHTREE PKY, NORCROSS 30092
MCCLATCHEY, WILLIAM M. 29 ACT IM
35 COLLIER RD NW STE 775, ATLANTA 30309
MCCLELLAND, W. SPENCE 29 R IM
20 MOUNT PARAN RD NE, ATLANTA 30342
MCCORD, CLINTON D., JR. 29 ACT OPH
1938 PEACHTREE RD NW STE 103, ATLANTA 30309
MCCORD, DALE L. 29 ACT TR
1000 JOHNSON FERRY RD NE, ATLANTA 30342
MCCOY, JDHN M. 29 ACT IM,RHU
993-C JOHNSON FERRY RD NE, ATLANTA 30342

MCCRANEY, JOHN M., JR. 29 ACT AN
35 LINDEN AVE, ATLANTA 30365
MCCROSKEY, MARION M. 29 ACT AN
315 BOULEVARD NE STE 100, ATLANTA 30312
MCDANIEL, J. STUART 29 ACT OBG
105 COLLIER RD NW STE 1080, ATLANTA 30309
MCDANIEL, J.G. 29 ACT GP
820 WEST WESLEY RD NW, ATLANTA 30327
MCDDNALD, ALLEN P. 29 ACT ORS
315 BOULEVARD NE STE 400, ATLANTA 30312
MCDDNALD, HARDLD P., JR. 29 ACT U
98 CURRIER ST NE, ATLANTA 30308
MCDONALD, LEWIS H. 29 ACT GS
3665 IVY RD, ATLANTA 30342
MCDONOUGH, L.ALLEN 29 ACT PD
960 JOHNSON FERRY RD NE, ATLANTA 30342
MCDDUGALL, WILLIAM L., JR. 29 ACT U
3250 HOWELL MILL RD NW, ATLANTA 30327
MCDUFFIE, FREDERIC C. 29 A RHU
1314 SPRING ST NW, ATLANTA 30309
MCGARITY, WILLIAM C. 29 ACT GS
1365 CLIFTON RD NE, ATLANTA 30322
MCGARITY, WILLIAM C., JR. 29 ACT IM
575 WEST PEACHTREE ST NE, ATLANTA 30308
MCGINTY, A. PARK 29 ACT IM
3290 WOOD VALLEY RD NW, ATLANTA 30327
MCGRAW, WALKER C. 29 ACT GS
6185 SOUTH BUFORD HWY C-112, NORCROSS 30071
MCKEE, DAVID S. 29 ACT
1230 JOHNSON FERRY RD, MARIETTA 30067
MCKENZIE, WILLIAM J., JR. 29 ACT OBG
5675 PEACHTREE-DUNWOODY RD, ATLANTA 30342
MCKINNEY, ALEXANDER S. 29 ACT N
1365 CLIFTON RD NE, ATLANTA 30322
MCKINNON, WILLIAM M. 29 ACT CDS
1942 BRECKENRIDGE DR, ATLANTA 30345
MCLEAN, DONALD C. 29 ACT A
1938 PEACHTREE RD NW, ATLANTA 30309
MCLEOD, DDNALD S. 29 ACT AN
5675 PEACHTREE DUNWOODY RD, ATLANTA 30342
MCLEOD, WALLACE N. 29 ACT D
340 BOULEVARD NE, ATLANTA 30312
MCPHEETERS, HAROLD L. 29 ACT P
1340 SPRING ST NW STE 400, ATLANTA 30309
MCSWEENEY, MARJORIE B. 29 ACT DR
EMORY UNIV HOSP RADIOLOGY, ATLANTA 30322
MEEHAN, PETER L. 29 ACT ORS
1001 JOHNSON FERRY RD NE, ATLANTA 30363
MEES, DDNALD E., JR. 29 ACT AN
1000 JOHNSON FERRY RD NE, ATLANTA 30342
MELTZER, HARDLD D. 29 ACT PTH
2736 FELTON DR, EAST POINT 30344
MENDELOFF, JOSEPH 29 S PTH
1670 CLAIRMONT RD NE, DECATUR 30033
MEREDITH, TRAVIS A. 29 ACT OPH
1365 CLIFTON RD NE, ATLANTA 30322
MERMIN, MARGARET 29 ACT IM
484 MORELAND AVE STE 300, ATLANTA 30307
MERRILL, ARTHUR J. 29 ACT IM
35 COLLIER RD NW, ATLANTA 30309
MERRILL, ARTHUR J., JR. 29 ACT CD
1968 PEACHTREE RD NW, ATLANTA 30309
MESSER, ALFRED A. 29 ACT P
801 DOUGLAS RD NE, ATLANTA 30342
MEYER, JOHN D. 29 ACT R
993-C JOHNSON FERRY RD NE, ATLANTA 30342
MILLAR, J. DONALD 29 S PH
1600 CLIFTON RD NE, ATLANTA 30333
MILLEDGE, ROBERT D. 29 ACT DR
1889 MERCEDES CT, ATLANTA 30345
MILLER, CHESTER O. 29 ACT P
1970 CLIFF VALLEY WAY NE, ATLANTA 30329
MILLER, JOSEPH I. 29 ACT CD
25 PRESCOTT ST NE, ATLANTA 30308
MILLER, LILA BONNER 29 ACT P
768 JUNIPER ST NE, ATLANTA 30308

MILLER, PRESTON R. 29 ACT IM
960 JOHNSON FERRY RD NE, ATLANTA 30342
MILSAP, JAMES H., JR. 29 ACT R
35 COLLIER RD NW STE 305, ATLANTA 30309
MINOR, H.W. 29 ACT IM
4665 PEACHTREE-DUNWOODY RD, ATLANTA 30342
MINOR, JAMES B. 29 ACT CD
960 JOHNSON FERRY RD NE, ATLANTA 30342
MIRSKY, ROBERT S. 29 ACT
1203 NOBLE FOREST DR, NORCROSS 30092
MITCHELL, DOROTHY E. 29 ACT END,GYN
80 BUTLER ST SE, ATLANTA 30335
MITCHELL, JAMES K., JR. 29 ACT OTO
5675 PEACHTREE-DUNWOODY RD, ATLANTA 30342
MITCHELL, MARVIN A. 29 ACT GS
3250 HOWELL MILL RD, ATLANTA 30327
MITCHELL, OTIS C. 29 ACT OBG
189 MEDICAL WAY STE C, RIVERDALE 30274
MITCHELL, RICHARD M. 29 ACT OBG
35 COLLIER RD STE 320, ATLANTA 30309
MITCHELL, WILLIAM E. 29 ACT GS
2377 WOODWARD WAY NE, ATLANTA 30305
MITCHELL, WILLIAM E., JR. 29 ACT GS
35 COLLIER RD NW, ATLANTA 30309
MITTENTHAL, MARK J. 29 ACT
993-D JOHNSON FERRY RD #360, ATLANTA 30342
MOBASSER, SHAPOUR 29 ACT OBG
960 JOHNSON FERRY RD NE, ATLANTA 30342
MODI, THOMAS A. 29 ACT OBG
993 JOHNSON FERRY RD NE, ATLANTA 30342
MOKAL, ALBERT J. 29 ACT R
35 LINDEN AVE NE, ATLANTA 30309
MOLDENHAUER, C. CRAIG 29 ACT AN
1364 CLIFTON RD NE, ATLANTA 30322
MOLKNER, KENNETH C. 29 ACT P
3400 PEACHTREE RD STE 1211, ATLANTA 30326
MONFORT, JOHN M. 29 ACT IM
6 LARK RD, HILTON HEAD IS SC 29928
MOORE, G. RICHARD 29 ACT OBG
1311 CLEVELAND AVE ' 305, EAST POINT 30344
MOORE, JOHN E. 29 ACT TS,CD
272 BOULEVARD NE, ATLANTA 30312
MOORE, W.W., JR. 29 ACT NS
25 PRESCOTT ST NE STE 4439, ATLANTA 30308
MOOREHEAD, FRANKIE L. 29 A PD
75 PIEDMONT AVE NE STE 470, ATLANTA 30303
MOORHEAD, CHRISTIAN R. 29 ACT OBG
75 PIEDMONT AVE NE, ATLANTA 30303
MOORHEAD, JOSEPH H. 29 A OBG
75 PIEDMONT AVE NE, ATLANTA 30303
MORAN, MARTIN J. 29 ACT PD
993-F JOHNSON FERRY RD NE, ATLANTA 30342
MORELAND, STEVEN C. 29 ACT OBG
105 COLLIER RD NW STE 1080, ATLANTA 30309
MORENO, HUGO S. 29 ACT OBG
2739 FELTON DR, EAST POINT 30344
MORGAN, HORACE L. 29 R OM
345 CASTLERIDGE DR NE, ATLANTA 30342
MORGAN, JAMES W. 29 ACT U
490 PEACHTREE ST STE 578-C, ATLANTA 30308
MORGAN, PHILIP E. 29 ACT OM
2000 NORTHEAST EXPY, NORCROSS 30071
MORGANSTERN, STEVEN L. 29 ACT U
3280 HOWELL MILL RD, ATLANTA 30327
MORK, VIRGINIA G. 29 I&R
GRADY MEMORIAL HOSPITAL, ATLANTA 30303
MORRIS, DOUGLAS C. 29 ACT IM
25 PRESCOTT ST NE, ATLANTA 30308
MORRIS, STEVEN J. 29 ACT IM
25 PRESCOTT ST NE STE 5404, ATLANTA 30365
MDRRISDN, WILLIAM N. 29 ACT U
340 BOULEVARD NE STE 409, ATLANTA 30312
MORRISSY, RAYMOND T. 29 ACT PD
1001 JOHNSON FERRY RD NE, ATLANTA 30363
MORTON, WILLIAM J. 29 ACT U
4553 NORTH SHALLOWFORD RD, ATLANTA 30338
MOYER, LERDY N. 29 ACT OBG
1175 PEACHTREE ST NE, ATLANTA 30309
MUNNA, JOHN C. 29 ACT PS
3280 HOWELL MILL RD NW, ATLANTA 30327
MURPHY, CHRISTINE H. 29 ACT R
1365 CLIFTON RD NE, ATLANTA 30322
MURPHY, MICHAEL R. 29 ACT AN
1364 CLIFTON RD NE, ATLANTA 30322
MURPHY, RALPH A., JR. 29 ACT IM
35 COLLIER RD NW, ATLANTA 30309
MURRAY, DOUGLAS R. 29 ACT GS
1365 CLIFTON RD NE, ATLANTA 30322
MURRAY, H. HERNDON 29 ACT ORS
1938 PEACHTREE RD NW STE 710, ATLANTA 30309
MUSSER, A. WENDELL 29 S
VA MEDICAL CENTER, DECATUR 30033
MYERS, ALLEN R. 29 ACT FP
1143 ALPHARETTA ST, ROSWELL 30075
MYERSON, GARY E. 29 ACT IM,RHU
960 JOHNSON FERRY RD, ATLANTA 30342
NAFFIS, DARIUS 29 ACT PD
993-D JOHNSON FERRY RD NE, ATLANTA 30342
NAGLER, STEPHEN M. 29 ACT GS,CRS
993-F JOHNSON FERRY RD, ATLANTA 30342
NAHAI, FOAD 29 ACT PS
25 PRESCOTT ST NE STE 5424, ATLANTA 30308
NAHMIAS, ANDRE J. 29 A PD
69 BUTLER ST SE, ATLANTA 30303
NAHMIAS, BRIGITTE 29 R IM
859 VISTAVIA CIR, DECATUR 30033
NAIR, VIMALA P. 29 ACT P
677 CHURCH ST, MARIETTA 30060
NAJAK, ZEBA D. 29 ACT PD
4575 NORTH SHALLOWFORD RD, ATLANTA 30338
NAKANO, PHILLIP H. 29 I&R GS
1968 PEACHTREE RD NW, ATLANTA 30309
NAPOLI, VICTOR M. 29 ACT PTH
80 BUTLER ST SE, ATLANTA 30303
NEELD, JOHN B. 29 ACT AN
3025 RIVER NORTH PKY, ATLANTA 30328
NEELY, F. LEVERING 29 ACT IM
35 COLLIER RD NW, ATLANTA 30309
NEWMAN, PHILIP E. 29 I&R OPH
2555-A NEW HAVEN DR, ATLANTA 30345
NEWSOM, NEAL H. 29 ACT OBG
2045 PEACHTREE RD NE, ATLANTA 30309
NEWTON, ZACHARIAH B., III 29 ACT OBG
490 PEACHTREE ST STE 353-B, ATLANTA 30308
NEZHAT, CAMRAN 29 ACT OBG
5675 PEACHTREE-DUNWOODY RD, ATLANTA 30342
NICHOLAS, EDMUND M. 29 ACT U
3280 HOWELL MILL RD STE 107, ATLANTA 30329
NICHOLS, JOSEPH J. 29 ACT CRS
490 PEACHTREE ST NE, ATLANTA 30308
NICKERSON, JOHN F. 29 ACT PTH
35 LINDEN AVE NE, ATLANTA 30308
NICOL, CHARLES F. 29 ACT N
315 BOULEVARD NE STE 224, ATLANTA 30312
NILES, GEORGE A., JR. 29 ACT GYN
2045 PEACHTREE RD NE STE 415, ATLANTA 30309
NINCIC, ALEXANDER 29 ACT U
478 PEACHTREE ST STE 905-A, ATLANTA 30308
NINO, HOMERO F. 29 S R
1670 CLAIRMONT RD, DECATUR 30033
NIPPERT, PHILIP H. 29 ACT D
478 PEACHTREE ST NE, ATLANTA 30308
NOLAN, THDMAS R. 29 ACT GS,CDS
1170 CLEVELAND AVE, EAST POINT 30344
NORTH, ALVIN W. 29 ACT OPH
2004 PEACHTREE RD NW, ATLANTA 30309
NORWOOD, WILLIAM F. 29 ACT PD
105 COLLIER RD NW STE 4060, ATLANTA 30309
NUGENT, ELIZABETH W. 29 ACT PD
EMORY UNIVERSITY, ATLANTA 30322
NUGENT, JEFFREY T. 29 ACT ORS
105 COLLIER RD NW STE 5000, ATLANTA 30309
NUNEZ, WILLIAM O. 29 ACT AN
2760-B FELTON DR, EAST POINT 30344
O'BARR, THOMAS B. 29 I&R
1075 BYRNWYCK TR, ATLANTA 30319
O'BRIEN, DAVID P. 29 ACT U
1365 CLIFTON RD NE, ATLANTA 30322
O'BRIEN, MARK S. 29 ACT NS
1365 CLIFTON RD NE, ATLANTA 30322
O'HANLAN, KATHERINE A. 29 I&R OBG
2078 LENOX RD NE, ATLANTA 30324
O'NEAL, BUFORD L. 29 ACT OTO
173 PUTNAM CIR NE, ATLANTA 30342
O'NEAL, PAMELA 29 ACT IM
1396 NORMANDY DR NE #1, ATLANTA 30306
O'QUIN, WILLIAM P. 29 R FP
2100 PARKLAKE DR NE STE 11, ATLANTA 30345
OETTINGER, CARL W. 29 ACT IM,NEP
25 PRESCOTT ST #6426, ATLANTA 30308
OLANSKY, ALAN J. 29 ACT D
401 WEST PEACHTREE ST NE, ATLANTA 30308
OLANSKY, DAVID C. 29 ACT D
401 WEST PEACHTREE ST NE, ATLANTA 30308
OLANSKY, MARIAN F. 29 R PD
1365 CLIFTON RD NE, ATLANTA 30322
OLANSKY, SIDNEY 29 ACT D
401 WEST PEACHTREE ST NE, ATLANTA 30308
OLLINS, ROBERT J. 29 ACT IM
565 WEST PEACHTREE ST NE, ATLANTA 30308
ORDONEZ, CARLOS 29 ACT R
1170 CLEVELAND AVE, EAST POINT 30344
ORR, A. STEPHENS 29 ACT OBG
490 PEACHTREE ST NE, ATLANTA 30308
ORR, DOUGLAS W. 29 ACT ON,HEM
993-D JOHNSON FERRY RD NE, ATLANTA 30342
ORR, JAMES B. 29 I&R
652 PARK LN, DECATUR 30033
ORTEGA, HERNANOO JOSE 29 ACT GS
2163 NORTHLAKE PKY STE 103-1, TUCKER 30084
OSBORNE, ELTON S., JR. 29 ACT PH
277 FAIRGROUND ST SE, MARIETTA 30060
OSTER, CAROL H. 29 ACT FP
6701 ROSWELL RD NE, ATLANTA 30328
OTIS, JOHN B. 29 ACT PTH
340 BOULEVARD NE, ATLANTA 30312
OWINGS, FRANCIS B. 29 ACT GS
478 PEACHTREE ST STE 717-A, ATLANTA 30308
PALAY, BERNARO H. 29 ACT IM,AL
1372 PEACHTREE ST NE, ATLANTA 30309
PALMER, JAMES D. 29 ACT IM
970 MARTIN L KING JR DR, ATLANTA 30314
PARKER, WILEY A. 29 ACT OTO
5669 PEACHTREE-DUNWOODY RD, ATLANTA 30342
PARNELL, R. PARKS, JR. 29 ACT FP
4384 OAKDALE RD, SMYRNA 30080
PARROTT, THOMAS S. 29 ACT U
993 JOHNSON FERRY RD NE, ATLANTA 30342
PATRACHAI, CHAVALIT C.P. 29 ACT
1325 PEACHTREE ST APT 901, ATLANTA 30309
PATTERSON, H. SCOTT 29 ACT P
3280 HOWELL MILL RD NW, ATLANTA 30327
PATTERSON, JDSEPH H. 29 ACT PD
1405 CLIFTON RD NE, ATLANTA 30322
PATTDN, JOHN W. 29 ACT AN
PO BOX 28637, ATLANTA 30358
PAULLIN, WILLIAM L., JR. 29 ACT IM
35 COLLIER RD NW, ATLANTA 30309
PAYNE, DOLFORD F., JR. 29 ACT GS
300 BOULEVARD NE, ATLANTA 30312
PAYNE, NETTLETON S. 29 ACT NS
993-F JOHNSON FERRY RD, ATLANTA 30342
PAYNE, PETER M. 29 ACT OBG
993-C JOHNSON FERRY RD NE, ATLANTA 30342
PEACOCK, LAMAR B. 29 ACT IM
478 PEACHTREE ST NE, ATLANTA 30308
PEARCE, T. ELDER, JR. 29 ACT GS
960 JOHNSON FERRY RD NE, ATLANTA 30342

PENDERGRAST, WILLIAM J. 29 ACT GS
478 PEACHTREE ST NE, ATLANTA 30308
PENDERGRAST, WILLIAM J., JR. 29 ACT PS
993 JOHNSON FERRY RD NE, ATLANTA 30342
PENNINGTON, E. EARL 29 ACT CRS
960 JOHNSON FERRY RD NE, ATLANTA 30342
PENTECOST, MARK P. 29 ACT OBG
35 COLLIER RD NW, ATLANTA 30309
PER-LEE, JOHN H. 29 ACT OTO,DT
EMORY UNIVERSITY CLINIC, ATLANTA 30322
PERDUE, GARLAND D., JR. 29 ACT GS
EMORY UNIVERSITY CLINIC, ATLANTA 30322
PEREZ, A.R. 29 ACT CDS
1311 CLEVELAND AVE, EAST POINT 30344
PERKINS, J. MORRIS 29 ACT P
3400 PEACHTREE RD NE STE 905, ATLANTA 30326
PERKINSON, NEIL G. 29 ACT ND
5669 PEACHTREE-DUNWOODY RD, ATLANTA 30342
PERLING, DAVID S. 29 ACT IM
4536 CHAMBLEE-DUNWOODY #141, ATLANTA 30338
PERLSTEIN, SUSAN S. 29 ACT P
3400 PEACHTREE RD NE, ATLANTA 30326
PERRY, SAMUEL W. 29 ACT PD
2820 OCEAN SHORE BL, ORMAND BEACH FL 32074
PESZCZYNSKI, MIECZYSLAW 29 ACT PM
1920 BRECKENRIDGE DR NE, ATLANTA 30329
PETERS, JAMES S., JR.MD 29 ACT R
4513 CLUB CIR NE, ATLANTA 30319
PETERS, MARGARET P. 29 S AN
1670 CLAIRMONT RD NE, DECATUR 30033
PETREK, JEANNE A. 29 ACT GS
25 PRESCOTT ST NE, ATLANTA 30308
PHILLIPS, ROGSBERT F. 29 ACT GS
20 LINDEN AVE, ATLANTA 30308
PHILLIPS, THOMAS W. 29 ACT TR
25 PRESCOTT ST, ATLANTA 30365
PHILLIPS, WENDELL E. 29 ACT OBG
11050 CRABAPPLE RD, ROSWELL 30075
PHRYDAS, IRENE A. 29 ACT P
3400 PEACHTREE RD NE, ATLANTA 30326
PINE, JEFFREY R. 29 ACT PUD
1365 CLIFTON RD NE, ATLANTA 30332
PIRKLE, CECIL H. 29 ACT GS
1311 CLEVELAND AVE, EAST POINT 30344
PIRKLE, QUENTIN R., JR. 29 ACT IM
105 COLLIER RD NW STE 2070, ATLANTA 30309
PIROZZI, DONALD J. 29 ACT D
105 COLLIER RD NW STE 2060, ATLANTA 30367
PITTMAN, FRANK S., III 29 ACT P
960 JOHNSON FERRY RD NE, ATLANTA 30342
PITTS, STEPHEN ROY 29 I&R IM
2537 ECHO DR NE, ATLANTA 30345
PLANZ, EDWARD J. 29 ACT CDS,TS
5669 PEACHTREE-DUNWOODY RD, ATLANTA 30342
PLUMMER, ALAN 29 ACT IM
1365 CLIFTON RD NE, ATLANTA 30322
POGUE, ROBERT H. 29 ACT P
2151 PEACHFORD RD, ATLANTA 30338
POLIAKOFF, SAMUEL R. 29 ACT OBG
105 COLLIER RD NW STE 3050, ATLANTA 30309
POLLARD, ZANE F. 29 ACT PD,DPH
2004 PEACHTREE RD NW, ATLANTA 30309
PONCE DE LEON, A.I. 29 ACT P
1970 CLIFF VALLEY WAY NE, ATLANTA 30329
POOLE, ROBERT NEIL 29 ACT PD
5675 PEACHTREE-DUNWOODY RD, ATLANTA 30342
PORTER, JERRY D. 29 ACT PTH
5665 PEACHTREE-DUNWOODY RD, ATLANTA 30342
POU, LEO H., JR. 29 ACT AN
2760-B FELTON DR, EAST POINT 30344
POUND, EDWIN C., JR. 29 ACT PS
993 JOHNSON FERRY RD NE, ATLANTA 30342
POWERS, ROBERT W. 29 ACT
105 COLLIER RD NW, ATLANTA 30309
PREAS, STEPHEN 29 A P
1970 CLIFF VALLEY WAY NE, ATLANTA 30329
PRICE, NORMA A. 29 ACT IM
993-D JOHNSON FERRY RD NE, ATLANTA 30342
PRUCE, ARTHUR 29 ACT PM
495 WOODWARD WAY NW, ATLANTA 30308
PRUCE, MARTA 29 ACT P
480 BROOKFIELD DR NE, ATLANTA 30342
PUTNAM, JAMES R. 29 ACT OS,OPH
25 PRESCOTT ST NE #3401, ATLANTA 30308
QUARTERMAN, KEITH A., JR. 29 ACT GS
960 JOHNSON FERRY RD NE, ATLANTA 30342
QUINONES, PEDRO P. 29 A PH
99 BUTLER ST SE, ATLANTA 30303
RAIFORD, MORGAN B. 29 ACT OPH
705 JUNIPER ST NE, ATLANTA 30308
RAINER, JOEL H. 29 I&R CD
56 MOBILE AVE NE, ATLANTA 30305
RAMAGE, JAMES E. 29 I&R IM
1101 COLLIER RD NW APT F2, ATLANTA 30318
RAMOS, HAROLD S. 29 ACT IM
35 LINDEN AVE NE, ATLANTA 30308
RAMSEY, JOHN E. 29 ACT OBG
35 COLLIER RD STE 375, ATLANTA 30309
RAND, EDGAR O. 29 ACT GS
RTE 1, SAUTEE 30571
RANKIN, JOSEPH L. 29 ACT D
384 PEACHTREE ST NE, ATLANTA 30308
RASMUSSEN, E.P. 29 ACT R
35 COLLIER RD NW, ATLANTA 30309
RATCHFORD, WALTER J. 29 ACT OBG
105 COLLIER RD NW #1080, ATLANTA 30309
RAUTH, VIRGINIA A. 29 ACT TR
5665 PEACHTREE-DUNWOODY RD, ATLANTA 30342
RAVRY, MARIO J.R. 29 ACT GE
478 PEACHTREE ST NE, ATLANTA 30308
RAY, DERRELL W. 29 ACT P
2151 PEACHFORD RD, ATLANTA 30338
RAY, JOHN W. 29 ACT R
1170 CLEVELAND AVE, EAST POINT 30344
RAY, LARRY G. 29 ACT
315 BOULEVARD NE STE 228, ATLANTA 30312
RAYEL, PETER A. 29 ACT IM
6500 VERNON WOODS DR NE, ATLANTA 30328
RAYLE, ALBERT A., JR. 29 ACT R
490 PEACHTREE ST NE, ATLANTA 30308
READ, JOSEPH C. 29 ACT GS
1108 ELM ST, DANVILLE KY 40422
REDD, BRYAN L., JR. 29 R TR
2662 FAIR OAKS RD, DECATUR 30033
REDD, STEPHEN S. 29 ACT PD
2758 FELTON DR, EAST POINT 30344
REED, W. THOMAS 29 ACT IM
6500 VERNON WOODS DR, ATLANTA 30328
REES, BRIGITTA A. 29 ACT PM
3280 HOWELL MILL RD STE 309, ATLANTA 30327
REEVES, MARTIN M. 29 ACT AN
5360 TIMBER TR NE, ATLANTA 30342
REEVES, W. HARRISON 29 ACT IM
478 PEACHTREE ST NE, ATLANTA 30308
REHERT, GERALD M. 29 ACT OBG
490 PEACHTREE ST STE 132-B, ATLANTA 30309
REICH, GEORGE A. 29 S PM
101 MARIETTA TOWER NW, ATLANTA 30323
REID, WILLIAM A. 29 ACT GS
340 BOULEVARD NE, ATLANTA 30312
REISMAN, HOWARD A. 29 ACT DBG
11050 CRABAPPLE RD, ROSWELL 30075
REITT, J. PETER 29 ACT NS
993-F JOHNSON FERRY RD, ATLANTA 30342
REYNAUD, L.F. 29 ACT PD
1278 GORDON ST SW, ATLANTA 30310
REYNAUD, VIRGINIA G. 29 ACT PD
1278 GORDON ST SW, ATLANTA 30310
REYNOLDS, J.S. 29 ACT FP
553 MOBILE AVE SW, ATLANTA 30315
RICCARDI, LOUIS S. 29 R GS
1297 SWIMS VALLEY DR NW, ATLANTA 30327
RICHARDSON, A. CULLEN, JR. 29 ACT OBG
105 COLLIER RD NW STE 3080, ATLANTA 30309
RICHARDSON, ARTHUR 29 ACT PA
977 CASTLE FALLS DR NE, ATLANTA 30322
RICHARDSON, H. DALE 29 ACT NS
315 BOULEVARD NE STE 300, ATLANTA 30312
RICHARDSON, STERLING H. 29 ACT GS
490 PEACHTREE ST STE 356-B, ATLANTA 30308
RICHMAN, GARY O. 29 ACT OPH
993-D JOHNSON FERRY RD NE, ATLANTA 30342
RICHMOND, ALAN N. 29 ACT OBG
5667 PEACHTREE DUNWOODY RD, ATLANTA 30342
RICHMOND, LEA 29 ACT GS
6500 VERNON WOODS DR, ATLANTA 30328
RICKS, HENRY C., JR. 29 ACT P
1218 WEST PACES FERRY RD NW, ATLANTA 30327
RICKS, R. LEWIS 29 A OBG
1047 GORDON ST SW, ATLANTA 30310
RIDDELL, CHRISTOPHER F. 29 ACT P
1938 PEACHTREE RD NW, ATLANTA 30309
RIDLEY, JOHN H. 29 ACT GYN
35 COLLIER RD NW, ATLANTA 30309
RIEPE, STANLEY P. 29 ACT GE
69 BUTLER ST SE, ATLANTA 30303
RIESER, JOHN C. 29 ACT OPH
3280 HOWELL MILL RD STE 211, ATLANTA 30327
RIGGINS, RICHARD S. 29 ACT ORS
1365 CLIFTON RD NE, ATLANTA 30322
RITCHEY, STERLING J. 29 ACT ORS

RITCHIE-HAYNES, PATRICIA 29 ACT OBG
1938 PEACHTREE RD NW STE 614, ATLANTA 30309
RIVKIN, LAWRENCE M. 29 ACT TS
490 PEACHTREE ST NE, ATLANTA 30308
RIZOR, RANDY F. 29 ACT AN
11585 ALPHARETTA ST, ROSWELL 30076
ROACH, GEORGE S., JR. 29 ACT OTO
3280 HOWELL MILL RD STE 304, ATLANTA 30327
ROBERTS, C. PURCELL 29 ACT IM
55-25TH ST NW, ATLANTA 30309
ROBERTS, STEWART R., JR. 29 ACT R
1365 CLIFTON RD NE, ATLANTA 30322
ROBERTSON, HARRY G. 29 ACT OPH
2200 NORTHLAKE PKY STE 325, TUCKER 30084
ROBINSON, PAUL H. 29 ACT CD
1365 CLIFTON RD NE RM 481, ATLANTA 30322
ROBINSON, RALPH L. 29 R PD
156 MOUNT PARAN RD NW, ATLANTA 30327
ROCKFELD, ROBERT D. 29 ACT ORS
4555 NORTH SHALLOWFORD RD, DUNWOODY 30338
RODRIGUEZ, A.P. 29 ACT U
340 BOULEVARD NE, ATLANTA 30312
RODRIGUEZ, FERNANDO 29 S IM
PO BOX 33115, N DECATUR 30033
RODRIGUEZ, MARTIN 29 ACT GP
4830 FULTON INDUSTRIAL BLVD, ATLANTA 30336
RODZEWICZ, PAUL J. 29 ACT IM
993-F JOHNSON FERRY RD NE, ATLANTA 30342
ROGERS, CHARLES G. 29 ACT DBG
993-D JOHNSON FERRY RD NE, ATLANTA 30042
ROGERS, HARRISON L., JR. 29 ACT GS
1938 PEACHTREE RD NW #601, ATLANTA 30309
ROGERS, J. HARRY 29 ACT GS
418 ALLISON DR NE, ATLANTA 30342
ROLLINS, LUTHER C. 29 ACT GS
35 COLLIER RD NW, ATLANTA 30309
ROMAN, CARLOS R. 29 ACT AN
2760-B FELTON DR, EAST POINT 30344
ROOKER, DONALD W. 29 ACT OTD
833 CAMPBELL HILL RD, MARIETTA 30060
ROSEN, ARNOLD J. 29 ACT GS
993-D JOHNSON FERRY RD NE, ATLANTA 30342
ROSENTHAL, DAVID 29 ACT DS
315 BOULEVARD NE, ATLANTA 30312
ROSSI, TONI L. 29 ACT IM
484 MORELAND AVE STE 300, ATLANTA 30307

ROSVOLL, RANDI V. 29 ACT PTH,BLB
35 LINDEN AVE NE, ATLANTA 30308
ROTHENBERG, MARVIN B. 29 ACT ORS
6500 VERNON WOODS DR NE, ATLANTA 30328
ROTTENBERG, HOWARD A. 29 ACT U
5667 PEACHTREE DUNWOODY RD, ATLANTA 30342
ROTTERSMAN, WILLIAM 29 ACT P
STE 300, ATLANTA 30327
ROUBEN, DAVID P. 29 ACT ORS
315 BOULEVARD NE, ATLANTA 30312
ROUGHTON, RALPH E., JR. 29 ACT P
1175 PEACHTREE ST NE, ATLANTA 30309
ROWE, THOMAS S. 29 ACT OPH
490 PEACHTREE ST NE, ATLANTA 30308
RUBIN, ROY MICHAEL 29 ACT ORS
5669 PEACHTREE-DUNWOODY RD, ATLANTA 30342
RUCKET, ALAN N. 29 ACT OBG
315 BOULEVARD NE, ATLANTA 30312
RUDDER, FRED F. 29 ACT GS
350 BOULEVARD NE, ATLANTA 30312
RUDER, ERNST M. 29 ACT R
1175 WEST GARMON RD, ATLANTA 30327
RUDY, RICHARD K. 29 S FP,PM
205 THIRD ST NE STE 4, ATLANTA 30308
RUSCA, JOHN A. 29 ACT PS
5667 PEACHTREE DUNWOODY RD, ATLANTA 30342
RUSSELL, E.K. 29 ACT IM
600 WEST PEACHTREE ST NE, ATLANTA 30308
RUSSELL, R. JAMES 29 ACT PS
3250 HOWELL MILL RD NW, ATLANTA 30327
SABRIN, RUSSELL L. 29 ACT ORS
11050 CRABAPPLE RD, ROSWELL 30075
SACKS, HARVEY N. 29 ACT CD
315 BOULEVARD NE STE 520, ATLANTA 30312
SACKS, LEONARD L. 29 ACT NPM
1968 PEACHTREE RD, ATLANTA 30309
SAFFAN, B.D. 29 ACT IM
25 PRESCOTT ST NE STE 6410, ATLANTA 30308
SAKER, A.F. 29 ACT OBG
1311 EAST CLEVELAND AVE, EAST POINT 30341
SALE, WALTER T. 29 ACT R
35 COLLIER RD NW, ATLANTA 30309
SAMMONS, EDWARD E. 29 ACT AN
EMORY UNIVERSITY HOSPITAL, ATLANTA 30322
SANDERS, C. VERNON 29 ACT IM
6500 VERNON WOODS DR NE, ATLANTA 30328
SANDERS, STEVEN L. 29 ACT GS
5667 PEACHTREE DUNWOODY RD, ATLANTA 30342
SARGENT, CARLTON W. 29 ACT OBG
6553 CHURCH ST, RIVERDALE 30274
SARMA, PUDIPEDDI R. 29 S HEM,ON
1670 CLAIRMONT RD, DECATUR 30033
SATCHER, MILTON B., JR. 29 ACT ORS
2788 BAYARD ST, EAST POINT 30344
SCALJON, WILLIAM M. 29 ACT U
35 COLLIER RD NW #700, ATLANTA 30309
SCANLON, BARRY F. 29 ACT P
1201 PEACHTREE ST NE, ATLANTA 30361
SCHAFFNER, DONALD P. 29 ACT GP,PDS
993-D JOHNSON FERRY RD NE, ATLANTA 30342
SCHATTEN, WILLIAM E. 29 ACT PS
3280 HOWELL MILL RD NW, ATLANTA 30327
SCHEIDT, KENNETH A. 29 ACT NM
25 PRESCOTT ST NE, ATLANTA 30308
SCHEINBAUM, C.N. 29 ACT
928 NORTH HIGHLAND AVE NE, ATLANTA 30306
SCHELLACK, J.K. 29 ACT GS
490 PEACHTREE ST NE, ATLANTA 30308
SCHERMERHORN, THOMAS J. 29 ACT OPH
384 PEACHTREE ST NE, ATLANTA 30308
SCHERR, JOHN M. 29 ACT IM
105 COLLIER RD STE 4030, ATLANTA 30309
SCHLANT, ROBERT C. 29 ACT IM
69 BUTLER ST SE, ATLANTA 30303
SCHLOSSBERG, MICHAEL 29 ACT OBG
2788 BAYARD ST, EAST POINT 30344
SCHMITT, ELBERT W., JR. 29 ACT ORS
1365 CLIFTON RD NE, ATLANTA 30322
SCHNAPPER, ROBERT A. 29 ACT N
315 BOULEVARD NE STE 224, ATLANTA 30312
SCHOBORG, THOMAS W. 29 ACT U
340 BOULEVARD NE STE 11, ATLANTA 30312
SCHRODER, J. SPALDING 29 ACT IM
1365 CLIFTON RD NE, ATLANTA 30322
SCHULTZ, ROBERT M. 29 ACT PDE,DIA
993-C JOHNSON FERRY RD NE, ATLANTA 30342
SCHWARTZ, FRED J. 29 ACT AN
35 COLLIER RD NW STE 560, ATLANTA 30309
SCHWARTZ, JAMES F. 29 ACT CHN
69 BUTLER ST SE, ATLANTA 30303
SCHWARTZ, SANFORD H. 29 ACT IM
4536 CHAMBLEE-DUNWOODY RD, ATLANTA 30338
SCHWARZMANN, STEPHEN W. 29 ACT ID
1365 CLIFTON RD NE, ATLANTA 30322
SCHWIN, ROBERT L. 29 ACT P
281 BOULEVARD NE, ATLANTA 30312
SCOTT, CHARLES, JR. 29 ACT U
340 BOULEVARD NE, ATLANTA 30312
SCOTT, THOMAS P., JR. 29 ACT PD
777 CLEVELAND AVE SW, ATLANTA 30315
SCOTT, WILLIAM M.W. 29 ACT P
2151 PEACHFORD RD, ATLANTA 30338
SEALEY, R. MITCHELL 29 ACT OBG
993-D JOHNSON FERRY RD NE, ATLANTA 30042
SEAVEY, PAUL W. 29 ACT IM
1365 CLIFTON RD NE, ATLANTA 30322
SEGALL, NATHAN 29 ACT A,IM
478 PEACHTREE ST NE, ATLANTA 30308
SERRA, MARIAN H. 29 I&R EM
80 BUTLER ST, ATLANTA 30303
SETTLE, JAMES, JR. 29 ACT PUD
3250 HOWELL MILL RD STE 301, ATLANTA 30327
SHACKELFORD, HUGH W. 29 ACT DR
993 JOHNSON FERRY RD NE, ATLANTA 30342
SHADEED, BAHEEG L. 29 ACT GS
1776 OLD SPRING HOUSE LN, DUNWOODY 30338
SHAMA, ZOUTHEIR A. 29 ACT GS
2536 COSMOS DR NE, ATLANTA 30329
SHANIK, EDWARD J. 29 ACT FP
1585 HOLCOMB BRIDGE RD, ROSWELL 30076
SHANKS, JAMES Z. 29 ACT IM
1005 HAMMOND DR, ATLANTA 30328
SHANTHA, TOTADA R. 29 ACT AN
300 BOULEVARD NE STE 243, ATLANTA 30312
SHEA, P.C., JR. 29 ACT GS
1510 BENT CREEK CT, DUNWOODY 30338
SHEHEE, WALTER H. 29 ACT P
1338 CLEVELAND AVE, EAST POINT 30344
SHELTON, LEE RAYMOND 29 A GS
2797 CAMPBELLTON RD, ATLANTA 30311
SHERMAN, JERALD J. 29 ACT OBG
2550 WINDY HILL RD #108, MARIETTA 30067
SHERMAN, ROGER T. 29 ACT GS
69 BUTLER ST SE, ATLANTA 30303
SHERRER, CARL WILLIS 29 ACT OBG
105 COLLIER RD NW STE 1080, ATLANTA 30309
SHESSEL, FRED S. 29 ACT U
5669 PEACHTREEE DUNWOODY RD, ATLANTA 30342
SHESSEL, HERBERT L. 29 ACT OBG
315 BOULEVARD NE STE 328, ATLANTA 30312
SHIRAZI, SYED H. 29 ACT IM,CD
4555 NORTH SHALLOWFORD RD, DUNWOODY 30338
SHIVERS, OLIN G. 29 ACT PD
47 PEACHTREE PARK DR NE, ATLANTA 30309
SHULER, ROBERT K. 29 ACT PD
105 COLLIER RD NW STE 4060, ATLANTA 30309
SHULMAN, MICHAEL G. 29 ACT IM,NEP
5669 PEACHTREE-DUNWOODY RD, ATLANTA 30342
SIEVERT, ALAN J. 29 ACT ADL,PD
3108 DODSON DR, EAST POINT 30344
SILVER, WILLIAM E. 29 ACT OTO,PS
4553 NORTH SHALLOWFORD RD, ATLANTA 30338
SILVERMAN, BARRY D. 29 ACT CD
1000 JOHNSON FERRY RD NE, ATLANTA 30342
SILVERMAN, MARK E. 29 ACT IM
1968 PEACHTREE RD NW, ATLANTA 30309
SILVERMAN, VICTOR E. 29 ACT IM
4536 CHAMBLEE-DUNWOODY RD, ATLANTA 30338
SILVERSTEIN, CHARLES M. 29 ACT R
1000 JOHNSON FERRY RD NE, ATLANTA 30342
SIMMONS, WILLIAM C. 29 ACT P
1970 CLIFF VALLEY WAY NE, ATLANTA 30329
SIMS, STUART E. 29 ACT GS
PO BOX 7800, ATLANTA 30357
SKANDALAKIS, JOHN E. 29 ACT GS
35 COLLIER RD NW, ATLANTA 30309
SKARDASIS, GEORGE M. 29 ACT CDS
25 PRESCOTT ST NE, ATLANTA 30308
SKOBBA, JOSEPH S. 29 ACT P
2386 DELLWOOD DR, ATLANTA 30305
SLADE, JOHN D. 29 ACT IM
768 JUNIPER ST NE, ATLANTA 30308
SLAUGHTER, HOWEL W., JR. 29 ACT CHP
1935 CLIFF VALLEY WAY NE, ATLANTA 30329
SLOAN, WYMAN P., III 29 ACT IM
340 BOULEVARD NE STE 324, ATLANTA 30312
SLUTSKY, MORTON 29 ACT PS
993-C JOHNSON FERRY RD NE, ATLANTA 30342
SMILEY, DAVID T. 29 ACT OTO
3250 HOWELL MILL RD, ATLANTA 30327
SMITH, ARTHUR A. 29 R OBG
3524 PRINCE GEORGE ST, EAST POINT 30344
SMITH, CARL A. 29 ACT AN
35 LINDEN AVE NE, ATLANTA 30308
SMITH, CARTER 29 ACT IM
35 COLLIER RD NW, ATLANTA 30309
SMITH, CARTER, JR. 29 ACT IM
35 COLLIER RD NW, ATLANTA 30309
SMITH, CHARLES W. 29 ACT OBG
57 SIXTH ST NE, ATLANTA 30308
SMITH, E.G., JR. 29 R R
35 LINDEN AVE NE, ATLANTA 30308
SMITH, JOEL P., JR. 29 ACT OTO
573 WEST PEACHTREE ST NE, ATLANTA 30308
SMITH, REGINALD D. 29 A IM
2855 CANDLER RD STE 6, DECATUR 30034
SMITH, RICHARD A., MD (11) 29 ACT NS
35 COLLIER RD NW, ATLANTA 30309
SMITH, RICHARD B. 29 ACT PD
5675 PEACHTREE-DUNWOODY RD, ATLANTA 30342
SMITH, RICHARD NOEL 29 ACT TS
5667 PEACHTREE DUNWOODY RD, ATLANTA 30342
SMITH, ROBERT B., III 29 ACT GS
1365 CLIFTON RD NE, ATLANTA 30322
SMITH, ROBERT W., III 29 ACT IM
478 PEACHTREE ST NE, ATLANTA 30308
SMITH, THOMAS F. 29 ACT PD,AL
69 BUTLER ST SE, ATLANTA 30303
SMITH, WILLIAM S. 29 ACT OTO
490 PEACHTREE ST STE 347-B, ATLANTA 30308
SNITZER, JOSEPH A., III 29 ACT PD
3162 PIEDMONT RD NE, ATLANTA 30305
SODER, PARRY D. 29 ACT R
5665 PEACHTREE-DUNWOODY NE, ATLANTA 30342
SOMEREN, AYTEN 29 A PTH
80 BUTLER ST SE, ATLANTA 30303
SOMEREN, TUNCER 29 ACT NEP
25 PRESCOTT ST NE, ATLANTA 30308
SOMMERVILLE, MARGARET J. 29 ACT FP
90 WEST WIEUCA RD NE, ATLANTA 30342
SOMOGYI, JAMES W. 29 ACT R,NM
50 LULLWATER PL, ATLANTA 30307
SONES, PETER J. 29 ACT DR
1364 CLIFTON RD NE, ATLANTA 30322
SORACCO, GERARDO J. 29 ACT TS
1311 EAST CLEVELAND AVE, EAST POINT 30344
SORSDAHL, OLIVER A. 29 ACT DR
300 BOULEVARD NE, ATLANTA 30312

SOWELL, DAVID S. 29 ACT GP
3580 ATLANTA AVE, HAPEVILLE 30354
SPANIER, JACOB A. 29 ACT OBG
315 BOULEVARD NE STE 328, ATLANTA 30312
SPEARMAN, WILLIAM B. 29 ACT IM
1938 PEACHTREE RD NW STE 705, ATLANTA 30309
SPECTOR, ROBERT H. 29 ACT N,OPH
1365 CLIFTON RD NE, ATLANTA 30322
SPIEGL, PAUL V. 29 ACT ORS
5667 PEACHTREE-DUNWOODY RD, ATLANTA 30342
ST. CLAIR, JANE T. 29 ACT AN
20 LINDEN AVE, ATLANTA 30308
ST. LOUIS, JOSEPH A., JR. 29 ACT OPH
275 CARPENTER DR, ATLANTA 30328
ST. PIERRE, RICK K. 29 I&R ORS
80 BUTLER ST SE, ATLANTA 30303
STAATS, ETHAN F. 29 ACT OTO
35 COLLIER RD NW, ATLANTA 30309
STACY, L. OAVIO 29 ACT PTH
5665 PEACHTREE-DUNWOODY RD, ATLANTA 30342
STALLINGS, WILLIAM P., JR. 29 ACT D
2732-A FELTON DR, EAST POINT 30344
STANTON, PAUL E., JR. 29 ACT GS
315 BOULEVARD NE, ATLANTA 30312
STAPLETON, SIDNEY L., JR. 29 ACT CDS
340 BOULEVARD NE, ATLANTA 30312
STARGEL, MICHAEL D. 29 ACT PTH
5665 PEACHTREE DUNWOODY RD, ATLANTA 30342
STATON, GERALO W., JR. 29 ACT PUD
25 PRESCOTT ST NE, ATLANTA 30365
STATON, TEO L. 29 ACT U
340 BOULEVARD NE #409, ATLANTA 30312
STEADMAN, HENRY E. 29 ACT GS
340 BOULEVARD NE STE 304, ATLANTA 30312
STEINBERG, DAVID L. 29 ACT IM
5669 PEACHTREE-DUNWOODY RD, ATLANTA 30342
STEINBERG, JAMES P. 29 ACT IM
1297 OAKDALE RD NE, ATLANTA 30307
STEINHAUS, JOHN E. 29 ACT AN
1365 CLIFTON RD NE, ATLANTA 30322
STEPHENS, J.RONALD 29 ACT GS
478 PEACHTREE ST NE, ATLANTA 30308
STEPHENSON, ROBERT H. 29 ACT GS
3250 HOWELL MILL RD NW #204, ATLANTA 30327
STEWART, CALVIN B. 29 ACT GS
103 TARRAGON CT, FRANKLIN TN 37064
STEWART, CHARLES P., JR. 29 ACT CHP
2151 PEACHFORD RD, ATLANTA 30338
STIVERS, ROBERT R. 29 ACT PTH
50 COCA-COLA PL SE, ATLANTA 30303
STOKES, J. JACK 29 ACT OPH
3280 HOWELL MILL RD NW, ATLANTA 30327
STONE, CHARLES F., JR. 29 ACT IM
35 COLLIER RD NW, ATLANTA 30309
STONE, LAWRENCE B. 29 ACT R
1000 JOHNSON FERRY RD NE, ATLANTA 30342
STONE, WILLIAM O. 29 ACT FP
478 PEACHTREE ST STE 722-A, ATLANTA 30365
STONER, CYRUS H. 29 ACT OPH
5200 LONG ISLAND DR NW, ATLANTA 30327
STOUDEMIRE, G. ALAN 29 ACT P
BOX 3903, DURHAM NC 27710
STRICKLER, C.W., JR. 29 ACT IM
212 TOWNSEND PL NW, ATLANTA 30327
STROUP, OAVIO G. 29 ACT OBG
1311 EAST CLEVELAND AVE, EAST POINT 30344
STUART, CARLOS A. 29 ACT IM
1938 PEACHTREE RD NW STE 705, ATLANTA 30309
STUART, WILLIAM H. 29 ACT IM
105 COLLIER RD NW, ATLANTA 30309
STURM, HIRAM MAXWELL 29 ACT D
1938 PEACHTREE RD NW, ATLANTA 30309
SUAREZ, RAMON A. 29 ACT OBG
105 COLLIER RD NW STE 2030, ATLANTA 30309
SULLIVAN, CARY E. 29 ACT PD
2555 CUMBERLAND PKY, ATLANTA 30339
SULLIVAN, LOUIS W. 29 ACT IM
720 WESTVIEW DR SW, ATLANTA 30310
SUMERS, KAREN D. 29 ACT OPH
3280 HOWELL MILL RD STE 207, ATLANTA 30329
SUNG, YUNG-FONG 29 ACT AN
EMORY UNIVERSITY HOSPITAL, ATLANTA 30322
SWANN, JULIAN W. 29 ACT D
478 PEACHTREE ST #1007, ATLANTA 30308
SYMBAS, PETER 29 ACT TS
69 BUTLER ST SE, ATLANTA 30303
SZECSEY, ALEXANDER 29 ACT OBG
1245 ALPHARETTA ST, ROSWELL 30075
TAFFEL, BRUCE H. 29 ACT OBG
993-D JOHNSON FERRY RD NE, ATLANTA 30042
TAIT, C. DOWNING, JR. 29 ACT P
3400 PEACHTREE RD NE, ATLANTA 30326
TALLEY, WILLIAM STEELE 29 A PH
4770 NORTH PEACHTREE RD, ATLANTA 30338
TANENBAUM, MARC A. 29 ACT PD
6667 VERNON WOODS DR NE, ATLANTA 30328
TANNER, OAVIO O. 29 ACT AL
1938 PEACHTREE ST NW STE 507, ATLANTA 30309
TANNER, JAMES C., JR. 29 R GS
1180 MOUNT PARAN RD NW, ATLANTA 30327
TARANTO, ALAN I. 29 ACT IM
993-D JOHNSON FERRY RD NE, ATLANTA 30342
TARANTO, MORRIS B. 29 ACT FP
478 PEACHTREE ST NE #107-A, ATLANTA 30308
TARCAN, YAVUZ A. 29 ACT NM,IM
1364 CLIFTON RD NE, ATLANTA 30322
TAUBER, CHARLES P. 29 ACT P
1218 WEST PACES FERRY RD NW, ATLANTA 30327
TAUBER, HARVEY B. 29 ACT U
5667 PEACHTREE DUNWOODY RD, ATLANTA 30342
TAYLOR, OAVID M. 29 ACT IM
340 BOULEVARD NE STE 214, ATLANTA 30312
TAYLOR, TERRY W. 29 ACT OPH
993-F JOHNSON FERRY RD NE, ATLANTA 30342
TAYLOR, WILLIAM J. 29 ACT FP
2049 PERKERSON RD SW, ATLANTA 30310
TEMPLES, POWELL M., JR. 29 DE4 P
145-15TH ST NE, ATLANTA 30361
TEPLIS, PAUL 29 ACT IM
3250 HOWELL MILL RD NW, ATLANTA 30327
THEBAUT, BEN R. 29 R GS
226 THE SOUTH CHASE, ATLANTA 30328
THITARAM, SOMPHONG 29 ACT GS
2351 BOLTON RD NW #116, ATLANTA 30318
THOMAS, KENNETH E. 29 ACT TS,CDS
5669 PEACHTREE-DUNWOODY RD, ATLANTA 30342
THOMAS, W. KEVIN 29 ACT OPH
5675 PEACHTREE-DUNWOODY RD, ATLANTA 30342
THOMPSON, ALBERT M., JR. 29 A AM,FP
2797 CAMPBELLTON RD STE B-1, ATLANTA 30311
THOMPSON, CAROL G. 29 ACT P
1935 CLIFF VALLEY WAY #225, ATLANTA 30329
THOMPSON, D.O. 29 ACT FP
478 PEACHTREE ST NE, ATLANTA 30308
THOMPSON, HUGH S., JR. 29 ACT ORS
PO DRAWER T, EAST POINT 30344
THOMPSON, JACK A. 29 ACT GS
1938 PEACHTREE RD NW, ATLANTA 30309
THOMPSON, JOHN O. 29 ACT OBG
16 PRESCOTT WALK NE, ATLANTA 30307
THOMPSON, JOHN W. 29 ACT PD
101 WEST WESLEY ST, WALHALLA SC 29691
THORNELOE, WILLIAM F. 29 ACT P
490 PEACHTREE ST NE, ATLANTA 30308
THORNTON, NATHANIEL A. 29 ACT IM
1938 PEACHTREE RD NW STE 705, ATLANTA 30309
THRASHER, BARRIE H., JR. 29 ACT OPH
3280 HOWELL MILL RD NW #207, ATLANTA 30327
THRONE, MARTIN L. 29 ACT IM
4536 CHAMBLEE-DUNWOODY RD, ATLANTA 30338
THWAITE, WALTER G. 29 R OBG
927 OAKDALE RD NE, ATLANTA 30307
TIOMORE, THOMAS L., JR. 29 ACT AN
1405 CLIFTON RD NE, ATLANTA 30322
TIMBERLAKE, LLOYD F. 29 ACT IM
35 COLLIER RD NW, ATLANTA 30309
TODD, CHARLES E., JR. 29 ACT GS
35 COLLIER RD NW, ATLANTA 30309
TOOMANN, DEXTER T. 29 A IM
401 WEST PEACHTREE ST NE, ATLANTA 30308
TOLER, EARLE Q. 29 ACT IM
2981 CHURCH ST, EAST POINT 30344
TOMEH, M.O. 29 ACT PD
2758 FELTON DR, EAST POINT 30344
TOOLE, WILLIAN NISBET 29 ACT U
6500 VERNON WOODS RD NE, ATLANTA 30328
TOPOROFF, STUART J. 29 ACT CD
5665 PEACHTREE-DUNWOODY RD, ATLANTA 30342
TORNOW, ABRAHAM M. 29 S IM
1436 BRIARCLIFF RD NE, ATLANTA 30306
TOWNSENO, DALE J. 29 S OS
PO BOX 499, PALMETTO 30268
TRITT, RAMIE ABRAHAM 29 ACT OTO
960 JOHNSON FERRY RD STE 350, ATLANTA 30342
TROPAUER, ALAN 29 ACT P
STE 400, ATLANTA 30305
TUCKER, R.P. 29 ACT GS
1603 WARE AVE, EAST POINT 30344
TUCKER, THOMAS S. 29 ACT IM
6500 VERNON WOODS DR STE A2, ATLANTA 30328
TURCOTTE, MAURICE R. 29 ACT AN
2760-B FELTON DR, EAST POINT 30344
TURK, L. NEWTON, III 29 ACT TS
35 COLLIER RD NW, ATLANTA 30309
TURNER, AUGUST B. 29 ACT GS
384 PEACHTREE ST NE, ATLANTA 30308
TURNER, CORBETT H. 29 ACT CHP
1711 UPPERGATE DR NE, ATLANTA 30307
TURNER, JOHN S., JR. 29 ACT OTO
EMORY UNIVERSITY CLINIC, ATLANTA 30322
TURNER, JOHN W. 29 ACT GS
3985 VERMONT RD NE, ATLANTA 30319
TURRENTINE, JOHN E. 29 ACT OBG
35 COLLIER RD NW STE 230, ATLANTA 30309
TURRENTINE, PAUL E. 29 ACT OBG
35 COLLIER RD NW, ATLANTA 30309
TYLER, RICHARO M. 29 A ORS
338 WEST PEACHTREE ST NE, ATLANTA 30308
ULLMAN, KARL H. 29 ACT IM
1311 CLEVELAND AVE, EAST POINT 30344
UNOERWOOO, FRANK O. 29 ACT DR
1968 PEACHTREE RD NW, ATLANTA 30309
UPCHURCH, W.E. 29 ACT U
1774 ATWOOD RD NE, ATLANTA 30305
UPSHAW, CHARLES B., JR. 29 ACT CD
35 COLLIER RD NW, ATLANTA 30309
UPSON, E.T. 29 R GS
RTE 7 BOX 241, CUMMING 30130
VAN BUREN, E. 29 ACT IM
870 CLIFTON RD NE, ATLANTA 30307
VAN BUREN, JAMES K. 29 ACT IM,PUD
490 PEACHTREE ST NE, ATLANTA 30308
VAN DE WETERING, R.J. 29 ACT P
5675 PEACHTREE-DUNWOODY RD, ATLANTA 30342
VANDERPOOL, GERALO E. 29 ACT P
6667 VERNON WOODS DR NE, ATLANTA 30328
VARGO, JAMES O. 29 ACT P
3985 SOUTH COBB DR, SMYRNA 30080
VARNER, JOHN B. 29 R OBG
1601 OCEAN DR S, JACKSONVILLE BCH FL 32250
VEATCH, J.W., JR. 29 ACT GS
25 PRESCOTT ST NE, ATLANTA 30308
VELAZCO, ANTENOR 29 ACT ORS
2788 BAYARD ST STE 2102, EAST POINT 30344
VELKOFF, ABRAHAM S. 29 ACT OBG
1175 PEACHTREE ST NE, ATLANTA 30309
VERLEY, KARL W. 29 ACT OBG
384 PEACHTREE ST STE 205, ATLANTA 30308

VILLANUEVA, LUDOVICO S. 29 ACT P
5840 ALLEN CT NE, SANDY SPRINGS 30328
VISINTINE, AAROLYN M. 29 A PD
4647 CLUB VALLEY DR NE, ATLANTA 30319
VOHMAN, MANN D. 29 ACT PTH
1968 PEACHTREE RD NW, ATLANTA 30309
VOLJAVEC, BOZIDAR F. 29 ACT IM
1311 CLEVELAND AVE, EAST POINT 30344
VON DER LAGE, F.C., JR. 29 ACT AN
35 COLLIER RD NW STE 560, ATLANTA 30309
VON HAAM, EMMERICH, JR. 29 ACT ORS
2788 BAYARD ST, EAST POINT 30344
WAGGONER, DAVID C. 29 ACT P
PO BOX 52645, ATLANTA 30355
WAITS, EDWARD JONES 29 ACT GS
960 JOHNSON FERRY RD NE, ATLANTA 30342
WALKER, EXUM B. 29 ACT NS
490 PEACHTREE ST STE 570-C, ATLANTA 30308
WALKER, R. JEFFREYS, III 29 ACT R
172 ATLANTA COUNTRY CLUB DR, MARIETTA 30067
WALLACE, STANLEY W. 29 ACT IM,CD
3995 LAWRENCEVILLE HWY, LILBURN 30247
WALLER, JOHN L. 29 ACT AN
1364 CLIFTON RD NE, ATLANTA 30322
WALTER, JONNE B. 29 ACT PUD
340 BOULEVARD NE STE 315, ATLANTA 30312
WALTON, KENNETH N. 29 ACT U
1365 CLIFTON RD NE, ATLANTA 30322
WARD, JOHN A. 29 S IM
1670 CLAIRMONT RD NE, DECATUR 30033
WARD, M. TERRY 29 A EM
2980 PONDVIEW CT, MARIETTA 30062
WARE, J. PATRICK 29 ACT CHP
2531 BRIARCLIFF RD STE 216, ATLANTA 30329
WARKENTIN, JOHN 29 ACT P
2905 PEACHTREE RD NE, ATLANTA 30363
WARREN, H. RUDOLPH 29 ACT P
2151 PEACHFORD RD, ATLANTA 30338
WARREN, W. DEAN 29 ACT GS
1364 CLIFTON RD NE, ATLANTA 30322
WASHBURN, LAWRENCE, JR. 29 R P
4620 WIEUCA RD, ATLANTA 30342
WASSERMAN, STANLEY B. 29 A PD
99 BUTLER ST SE, ATLANTA 30303
WATERS, WILLIAM C., III 29 ACT IM
35 COLLIER RD NW, ATLANTA 30309
WATKINS, W. LORRAINE 29 ACT PD
1935 CLIFF VALLEY WAY NE, ATLANTA 30329
WATSON, DAVID T. 29 ACT IM
35 COLLIER RD NW STE 500, ATLANTA 30309
WATSON, FRANCIS M., JR. 29 ACT ORS
1938 PEACHTREE RD NE STE 603, ATLANTA 30309
WATTERS, JULIAN Q. 29 R PD
4770 NORTH PEACHTREE RD NE, ATLANTA 30338
WEBSTER, ROBERT M. 29 ACT IM,A
2665 ACADIA ST, EAST POINT 30344
WEENS, H.S. 29 ACT R
80 BUTLER ST SE, ATLANTA 30303
WEINSTEIN, M. LOUIS 29 ACT DR
11585 ALPHARETTA ST, ROSWELL 30076
WEINSTEIN, MICHAEL N. 29 ACT IM
11050 CRABAPPLE RD STE 115D, ROSWELL 30075
WEISS, HARVEY A. 29 ACT PS
993-D JOHNSON FERRY RD NE, ATLANTA 30342
WELLS, PHILIP H. 29 ACT AN
5665 PEACHTREE-DUNWOODY RD, ATLANTA 30342
WELLS, ROBERT E. 29 ACT ORS
105 COLLIER RD NW STE 5000, ATLANTA 30309
WENGER, JULIUS 29 S IM
69 BUTLER ST, ATLANTA 30303
WENGER, NANETTE K. 29 A CD
69 BUTLER ST SE, ATLANTA 30303
WEST, ROBERT M. 29 ACT GP
1134 MAIN ST, FOREST PARK 30050
WEST, ROGER G. 29 I&R R
1364 CLIFTON RD NE, ATLANTA 30322
WHALEY, WILLIAM H. 29 ACT IM
3250 HOWELL MILL RD NW, ATLANTA 30327
WHEATLEY, JOSEPH K. 29 ACT U
1365 CLIFTON RD NE DEPT UROL, ATLANTA 30322
WHEELER, JAMES H. 29 ACT FP,P
993-F JOHNSON FERRY RD NE, ATLANTA 30342
WHIDDER, DESIDERIUS C. 29 ACT GS
490 PEACHTREE ST, ATLANTA 30308
WHIPPLE, STEPHEN B. 29 ACT P
1938 PEACHTREE RD NW, ATLANTA 30309
WHISNANT, CHARLES L., JR. 29 R IM
4760 TALL PINES DR NW, ATLANTA 30327
WHITAKER, WILLIAM G., JR. 29 ACT GS
35 COLLIER RD NW, ATLANTA 30309
WHITE, PERRY M. 29 R ORS
1547 CAVE RD NW, ATLANTA 30327
WHITESIDES, THOMAS E., JR. 29 ACT ORS
EMORY UNIVERSITY CLINIC, ATLANTA 30322
WHITNEY, DOUGLASS G. 29 ACT CDS
993-F JOHNSON FERRY RD NE, ATLANTA 30342
WHYTE, DANA F. 29 ACT AN
1000 JOHNSON FERRY RD, ATLANTA 30342
WIEGAND, STEWART E. 29 ACT D
6500 VERNON WOODS DR, ATLANTA 30328
WIGGINS, ROY A., JR. 29 ACT IM
105 COLLIER RD NW, ATLANTA 30309
WILBER, JOSEPH A. 29 ACT IM
300 INTERSTATE N, ATLANTA 30339
WILCOX, ROBERT B. 29 ACT U
25 PRESCOTT ST NE STE 6434, ATLANTA 30308
WILDSTEIN, ALBERT 29 ACT GS
849 PEACHTREE ST NE, ATLANTA 30308
WILDSTEIN, WALTER B. 29 ACT GS
849 PEACHTREE ST NE, ATLANTA 30308
WILKES, JOSEPH S. 29 ACT ORS
35 COLLIER RD NW STE 520, ATLANTA 30367
WILKIEMEYER, RALPH M. 29 ACT U
3280 HOWELL MILL RD NW, ATLANTA 30327
WILKINS, S.A., JR. 29 R ND

WILKS, STEPHEN M. 29 ACT DR
35 COLLIER RD NW STE 305, ATLANTA 30309
WILLEY, LOY W. 29 ACT OPH
1275 CLEVELAND AVE, EAST POINT 30344
WILLIAMS, ANDRE D. 29 ACT OBG
3011 RAINBOW DR STE A, DECATUR 30034
WILLIAMS, BYRON 29 ACT CD
5665 PEACHTREE DUNWOODY RD, ATLANTA 30342
WILLIAMS, GEORGE A. 29 ACT OBG
135 MONTGOMERY FERRY RD NE, ATLANTA 30309
WILLIAMS, RALPH C. 29 R PH
2216 LESTER DR, ALBUQUERQUE NM 87112
WILLIAMS, ROBERT A. 29 ACT OM,FP
3900 MOTORS IND WAY, DORAVILLE 30360
WILLIAMS, WILLIS H. 29 ACT OS
1365 CLIFTON RD NE, ATLANTA 30322
WILLINGHAM, ROBERT T., JR. 29 ACT ORS
35 COLLIER RD NW, ATLANTA 30309
WILSON, COLON H., JR. 29 ACT IM
1365 CLIFTON RD NE, ATLANTA 30322
WILSON, FRANK L., JR. 29 ACT GS
35 COLLIER RD NW, ATLANTA 30309
WILSON, J.S. 29 ACT IM
490 PEACHTREE ST NE, ATLANTA 30308
WILSON, JOHN P. 29 ACT GS
315 BOULEVARD NE, ATLANTA 30312
WILSON, LOUIS A. 29 ACT OPH
1365 CLIFTON RD NE, ATLANTA 30322
WINNER, JONATHAN D. 29 ACT PD
6500 VERNON WOODS DR NE, ATLANTA 30328
WINOKUR, STANLEY H. 29 ACT ON
993-D JOHNSON FERRY RD NE, ATLANTA 30342
WITRAK, BONNIE J. 29 I&R R
80 BUTLER ST SE, ATLANTA 30303
WOFFORD, MICHAEL W. 29 ACT OS
315 BOULEVARD NE STE 100, ATLANTA 30312
WOLFF, BERNARD P. 29 ACT IM
2643 DELLWOOD DR NW, ATLANTA 30305
WOLFF, JOHN MCD. 29 ACT IM
35 COLLIER RD NW, ATLANTA 30309
WOLFMAN, RICHARD M. 29 ACT R
993 JOHNSON FERRY RD NE, ATLANTA 30342
WOOD, JAMES H. 29 ACT NS
1365 CLIFTON RD NE, ATLANTA 30322
WOOD, MARCELLA D. 29 R PD
3764 BRIARCLIFF RD NE, ATLANTA 30345
WOOD, WARNER, JR. 29 ACT ORS
5669 PEACHTREE-DUNWOODY RD, ATLANTA 30342
WOOD, WILLIAM A., JR. 29 R IM
3764 BRIARCLIFF RD NE, ATLANTA 30345
WOODARD, JOHN R. 29 ACT U
1365 CLIFTON RD NE, ATLANTA 30322
WOODHAMS, J. TREVOR 29 ACT OPH
3280 HOWELL MILL RD NW, ATLANTA 30327
WOODSIDES, KENNETH T. 29 ACT OM
125 PERIMETER CENTER WEST, ATLANTA 30348
WOODSON, G.C., JR. 29 ACT IM
6500 VERNON WOODS DR NE, ATLANTA 30328
WOODWARD, R. CRAIG 29 ACT IM
35 COLLIER RD NW STE 500, ATLANTA 30309
WOODY, EDGAR, JR. 29 ACT IM
35 COLLIER RD NW, ATLANTA 30309
WORTH, JACK J., JR. 29 R GS
888 ARTWOOD RD NE, ATLANTA 30307
WRIGHT, CHARLES K. 29 ACT OBG
35 COLLIER RD NW, ATLANTA 30309
WRIGHT, GEORGE E. 29 ACT ORS
35 COLLIER RD NW STE 520, ATLANTA 30309
WRIGHT, JOHN D. 29 ACT OPH
25 PRESCOTT ST NE, ATLANTA 30308
WYATT, THOMAS E. 29 ACT PD
833 CAMPBELL HILL ST, MARIETTA 30060
YAGER, HOWARD S. 29 ACT FP
3109 EAST SHADOWLAWN AVE NE, ATLANTA 30305
YANCEY, ASA G. 29 ACT GS
80 BUTLER ST SE, ATLANTA 30303
YARN, CHARLES P., JR. 29 ACT PS
35 COLLIER RD NW, ATLANTA 30309
YAUGER, JOHN THOMAS 29 ACT IM
575 WEST PEACHTREE ST NW, ATLANTA 30308
YOBS, ANNE ROOF 29 S PH
2687 OVERLOOK DR NE, ATLANTA 30345
YOCHEM, AUGUST S., JR. 29 ACT P
1970 CLIFF VALLEY WAY NE, ATLANTA 30329
YOUNGLESON, SHARON J. 29 ACT P
1970 CLIFF VALLEY WAY NE, ATLANTA 30329
ZAKI, SALEH A. 29 ACT FOP
50 COCA COLA PL SE, ATLANTA 30303
ZANE, RICHARD C. 29 ACT OBG
4555 NORTH SHALLOWFORD RD, ATLANTA 30338
ZAWORSKI, ROBERT E. 29 ACT PS
11050 CRABAPPLE RD STE 114, ROSWELL 30075
ZEE, HUGO 29 ACT P
3280 HOWELL MILL RD STE 323, ATLANTA 30327
ZEICHNER, WILLIAM D. 29 I&R GS
3000 BIG CREEK CT, ALPHARETTA 30201
ZIMMERMAN, MARK J. 29 ACT OBG
315 BOULEVARD NE STE 328, ATLANTA 30312
ZUBOWICZ, VINCENT N. 29 ACT PS
25 PRESCOTT ST NE, ATLANTA 30308

30—GLYNN

ADDISON, BENJAMIN ALFRED 30 ACT GS
1001 NORTH THIRD ST, FOLKSTON 31537
ADICKES, H.F., JR. 30 ACT P
412 OCEAN BLVD, ST SIMONS IS 31522
AMIE, JACK M. 30 ACT U
2418 PARKWOOD DR, BRUNSWICK 31520
ARMSTRONG, NATHANIEL E. 30 ACT GS
PO BOX 1258, BRUNSWICK 31520

AUSTIN, WILLILAM F. 30 ACT FP
3011 KEMBLE, BRUNSWICK 31520
AVERA, JOHN B. 30 ACT GS

BELLAM, RAMAMOHANA R. 30 ACT AN
3215 SHRINE RD, BRUNSWICK 31520
BERMAN, IRWIN R. 30 ACT CRS
2301 PARKWOOD DR, BRUNSWICK 31520
BROWN, OWIGHT J., JR. 30 ACT OBG
3020 SHRINE RD, BRUNSWICK 31520
BROWN, JOSEPH E. 30 ACT ORS
3208 SHRINE RD, BRUNSWICK 31520
BURBAN, THOMAS 30 ACT IM,EM
221 HERMITAGE WAY, ST SIMONS IS 31522
BURN, JOHN F. 30 R PD
749 DEER RUN VILLAS, ST SIMONS IS 31522
CHANEY, RALPH H., JR. 30 ACT AN
3226 HAMPTON AVE, BRUNSWICK 31520
COE, H.M. 30 ACT ORS
1120 PALMETTO AVE, BRUNSWICK 31520
DELEVETT, ALLEN F. 30 ACT IM
520 OCEAN BLVD, ST SIMONS IS 31522
DIXON, JIMMY L. 30 ACT PS
3215 SHRINE RD, BRUNSWICK 31520
DOUGLASS, THOMAS G. 30 ACT IM
PO BOX 1026, SEA ISLAND 31561
OUNKELBERGER, J.A. 30 R OTO
139 BELLE POINT PKY, BRUNSWICK 31520
ELLIS, RALPH GRIER, JR. 30 ACT AN
100 DARIEN HWY, BRUNSWICK 31520
FELONG, MICHAEL F. 30 ACT IM
2922 LA COSTA AVE, CARLSBAD CA 92008
FIX, RICHARO M. 30 ACT PD
2705 WILDWOOD DR, BRUNSWICK 31520
FLOURNOY, HENRY W. 30 ACT OBG
2444 PARKWOOD DR, BRUNSWICK 31520
FREEMAN, WILLIAM T. 30 ACT AN
PO BOX 1354, BRUNSWICK 31521
FRIEOMAN, MARK F. 30 ACT P,CHP
2927 DEMERE RD, ST SIMONS IS 31522
FRIEORICH, ERIC W. 30 ACT OTO
3216 SHRINE RD, BRUNSWICK 31520
FUTCH, C.B. 30 ACT GS
2432 PARKWOOD DR, BRUNSWICK 31520
GALLOWAY, BENJAMIN T. 30 ACT GS
303 MARSHVIEW CONDOMINIUMS, BRUNSWICK 31520
GOOBEY, PATRICK E.T. 30 ACT OBG
3226 HAMPTON AVE 'A, BRUNSWICK 31520
GOOBEY, RENEE E.W. 30 ACT AN
2444 PARKWOOD DR, BRUNSWICK 31523
GOWEN, JAMES F. 30 ACT OBG
3226 HAMPTON AVE-A, BRUNSWICK 31520
GRUBB, WILLIAM G. 30 ACT IM
2705 WILDWOOD DR, BRUNSWICK 31520
HAGEN, ARTHUR R. 30 ACT ORS
3010 HAMPTON AVE, BRUNSWICK 31520
HALEY, WILLIAM E. 30 ACT IM
2444 PARKWOOD DR, BRUNSWICK 31520
HAMILTON, NEWELL M. 30 ACT PD
2601 PARKWOOD DR #2, BRUNSWICK 31520
HARDEN, W.E. 30 ACT R
3010 HAMPTON AVE, BRUNSWICK 31520
HICKS, W.L., JR. 30 ACT EM
PO BOX 1956, BRUNSWICK 31521
HIGHTOWER, JOHN A. 30 ACT IM
MARSHVIEW CIRCLE DR, BRUNSWICK 31520
HUMPHRIES, WILLIAM C. 30 R GS
13 TANGLEWOOD RD, ST SIMONS IS 31522
HUNT, JESSE L. 30 ACT FP
PO BOX 1956, BRUNSWICK 31521
IMHOFF, JOHN E. 30 I&R OPH
3215 SHRINE RD, BRUNSWICK 31520
IMHOFF, LYNNE H. 30 I&R AN
3215 SHRINE RD, BRUNSWICK 31520
INMAN, WILLIAM O., JR. 30 ACT FP
2700 PARKWOOD DR, BRUNSWICK 31523
JENNINGS, E.R. 30 ACT GS
2514 WREN ST, BRUNSWICK 31520
JOHNSON, C.M. 30 ACT P
PO BOX 1830, ST SIMONS IS 31522
JOLLEY, FLEMING L. 30 ACT NS
BOX 205, SEA ISLAND 31561
JONES, HURLEY D., JR. 30 ACT IM
4036 RIVERSIDE DR, BRUNSWICK 31520
JOSEY, JOHN S. 30 ACT OPH
3010 HAMPTON AVE, BRUNSWICK 31520
KING, CHARLES R. 30 ACT ORS
3204 SHRINE RD, BRUNSWICK 31523
LAWS, WILLIAM J. 30 ACT IM
3212 SHRINE RD, BRUNSWICK 31520
LIM, ASTOR T. 30 ACT GP
103 SHERWOOD FOREST CIR, BRUNSWICK 31520
MANNING, OONALD H. 30 ACT R
3010 HAMPTON AVE, BRUNSWICK 31520
MAYO, EDWIN A. 30 ACT FP
3215 SHRINE RD, BRUNSWICK 31520
MILLER, ROBERT H. 30 ACT EM
PO BOX 1956, BRUNSWICK 31521
MITCHELL, FRANK B., JR. 30 ACT GS
83 MALLORY VILLAS, ST SIMONS IS 31522
MOORE, HAYWOOD L. 30 R IM
123 ARTHUR MOORE DR, ST SIMONS IS 31522
NICHOLSON, WILLIAM L. 30 ACT OTO
3228 SHRINE RD, BRUNSWICK 31520
NUTT, RICHARO L., JR. 30 ACT AN
PO BOX 1316, BRUNSWICK 31521
OSTA, SALIM M. 30 ACT ON
280 REDFERN VILLAGE, ST SIMONS IS 31522
OWENS, JOSEPH L. 30 ACT TS
3208 SHRINE RD, BRUNSWICK 31520
PARKE, JAMES G. 30 ACT GS
613 OLD PLANTATION, JEKYLL IS 31520
PAYNE, WOODROW W. 30 ACT U
3104 SHRINE RD, BRUNSWICK 31520
PIERCE, MART T. 30 ACT FP
PO BOX 1003, BRUNSWICK 31520
RASMUSSEN, WARREN A. 30 ACT PH
PO BOX 1219, BRUNSWICK 31520
RENTZ, TURNER W. 30 ACT FP
2514 WREN ST, BRUNSWICK 31520
RITTGERS, ROBIN A. 30 ACT IM,GE
3215 SHRINE RD, BRUNSWICK 31520
ROBERTS, DON R., JR. 30 ACT ORS
3204 SHRINE RD, BRUNSWICK 31523
ROORIGUEZ, ADRIANA M. 30 ACT R
3010 HAMPTON AVE, BRUNSWICK 31520
SALEEBY, PHILIP R. 30 ACT IM,PUD
3212 SHRINE RD, BRUNSWICK 31520
SCIPLE, GEORGE W. 30 ACT P
2601 PARKWOOD DR, BRUNSWICK 31520
SEGERBERG, ERIC C. 30 ACT GS
3215 SHRINE RD, BRUNSWICK 31520
SHAFFER, CARY 30 ACT FP,EM
203 FIVE POUNDS RD, ST SIMONS IS 31522
SIMMONS, MACK 30 ACT GS
DOVER BLUFF CLUB 84, WAVERLY 31565
SKELTON, LANA S. 30 ACT IM
3212 SHRINE RD, BRUNSWICK 31520
SKELTON, MARVIN E. 30 ACT R
3010 HAMPTON AVE, BRUNSWICK 31523
SMITH, JOHN M. 30 ACT IM
PO BOX 1059, ST SIMONS IS 31522
SMITH, MILLEDGE GLENN 30 ACT FP
3012 SHRINE RD, BRUNSWICK 31520
SNYDER, WILLARD A. 30 ACT FP
2700 PARKWOOD DR, BRUNSWICK 31523
STRICKLAND, AVERY W. 30 ACT IM
3010 HAMPTON AVE, BRUNSWICK 31520
SWANN, R.WADE, JR. 30 ACT D
3215 SHRINE RD, BRUNSWICK 31520
TAYLOR, HOWARD P. 30 ACT FP,OBG
PO DRAWER 855, SEA ISLAND 31561
THAGARD, ROY FRANK 30 ACT PD
2927 DEMERE RD, ST SIMONS IS 31522
TUTEN, CARROLL 30 ACT OPH
3011 KEMBLE AVE, BRUNSWICK 31520
VAN DYKE, PAUL B. 30 ACT FP
PO DRAWER N, BRUNSWICK 31521
WATT, JAMES A. 30 ACT P,PTH
PO DRAWER 1291, DARIEN 31305
WHEELER, GEORGE B., III 30 ACT OBG
3020 SHRINE RD, BRUNSWICK 31520
WILLIS, TOM V., JR. 30 ACT GS
3215 SHRINE RD, BRUNSWICK 31520
WILSON, C.A., JR. 30 ACT FP
PO BOX 1956, BRUNSWICK 31521
WRIGHT, MALCOLM G. 30 I&R IM
520 OCEAN BLVD STE 115, ST SIMONS IS 31522

31—GORDON

BISHOP, JOSEPH A. 31 ACT FP
PO BOX 247, CALHOUN 30701
BUTTERFIELD, ARTHUR E. 31 ACT OBG
PO BOX 667, CALHOUN 30701
BYERS, KENNETH W. 31 ACT IM
2 HOSPITAL CT, CALHOUN 30701
ESENER, ISMAIL 31 ACT OBG
PO BOX 1238, CALHOUN 30701
GENT, JACK 31 ACT GS
PO BOX 849, CALHOUN 30701
HALL, W.O. 31 ACT GS
SOUTH WALL ST, CALHOUN 30701
HAMMONO, OEWEY 31 ACT FP
TENNESSEE ST, FAIRMOUNT 30139
HAUCK, LORAN D. 31 ACT IM
RED BUD RD, CALHOUN 30701
HOAG, JOEL B. 31 ACT ORS
PO BOX 1507, CALHOUN 30701
JENKINS, MORRIS L. 31 ACT FP
BOX 125, CALHOUN 30701
MIRON, EOWARD J. 31 ACT FP
PO BOX 125, CALHOUN 30701
MOYE, ROBERT J. 31 ACT GS
REDBUD RD, CALHOUN 30701
PLANK, IRVIN E. 31 ACT AN,OBG
PO BOX 619, RESACA 30735
PURCELL, BILL 31 ACT FP
MEDICAL ARTS CENTER, CALHOUN 30701
RABB, J.L. 31 ACT FP
MEDICAL ARTS CENTER, CALHOUN 30701
SELF, THOMAS A. 31 ACT FP
#4 HOSPITAL CT, CALHOUN 30701
STEELE, BYRON H. 31 ACT FP
PO BOX 128, FAIRMOUNT 30139
THOMPSON, WILLIAM R. 31 ACT GP
MEDICAL ARTS CENTER, CALHOUN 30701
WALTER, R.D. 31 ACT FP
SOUTH WALL ST, CALHOUN 30701
WEAVER, LESLIE L. 31 ACT PTH
GORDON HOSPITAL, CALHOUN 30701

32—DOUGLAS

ANAGNOSTAKIS, JOHN G. 32 ACT FP
9507 HWY 5, DOUGLASVILLE 30135
BARROW, J. GORDON 32 ACT IM
110-B DOUGLAS MED COMPLX, DOUGLASVILLE 30134
BEACH, WILLIAM R., III 32 ACT PTH
8954 HOSPITAL DR, 105-B, DOUGLASVILLE 30134
BUSSEY, JOSEPH G., JR. 32 ACT GS
5990 LOVE ST, AUSTELL 30001

COLIER, HOWARD J. 32 ACT ORS
1001 ATLANTA W BLVD, LITHIA SPRINGS 30057
FIGUEREDO, JORGE V. 32 ACT GS
1001 THORNTON RD #414, LITHIA SPRINGS 30057
HUBER, DOUGLAS C. 32 ACT PTH
DOUGLAS GEN HOSPITAL, DOUGLASVILLE 30134
HULL, JAMES D., III 32 ACT GS
8954 HOSPITAL DR ' 105C, DOUGLASVILLE 30134
KUMAR, SURENDER V. 32 ACT OBG
1004 THORNTON RD 103, LITHIA SPRINGS 30057
KUMAR, VEENI S. 32 ACT PTH
3327 HWY 5, DOUGLASVILLE 30134
MANNES, HARVEY A. 32 ACT U
1001 THORNTON RD, 205, LITHIA SPRINGS 30057
NEGRI, FRANCISCO JOSE 32 ACT TS
8954 HOSPITAL DR, 115C, DOUGLASVILLE 30134
ROBINSON, A. CLARK 32 ACT FP
PO BOX 1118, DOUGLASVILLE 30133
SHAH, KIRITKUMAR J. 32 ACT GP,P
9507 HIGHWAY 5, DOUGLASVILLE 30135
STRICKLER, D.T., JR. 32 ACT FP
PO BOX 519, DOUGLASVILLE 30133
TAYLDR, THOMAS B. 32 ACT US
PO BOX 698, DOUGLASVILLE 30134
WU, CHEN N. 32 ACT GS
8954 HOSPITAL DR #105A, DOUGLASVILLE 30134

33—HABERSHAM

ARORA, OM P. 33 ACT GS
221 NORTH MAIN ST, CORNELIA 30531
ARORA, VIJAY 33 ACT PD
221 NORTH MAIN ST, CORNELIA 30531
GARRISON, FLETCHER D. 33 ACT FP
912 WAYSIDE ST, CORNELIA 30531
HARMON, JAMES C. 33 ACT FP
553 SOUTH MAIN ST, CORNELIA 30531
HICKS, L.G., JR. 33 ACT AN
MADISON ST, CLARKESVILLE 30523
LUMSDEN, THOMAS N. 33 ACT FP
PO BOX 45, CLARKESVILLE 30523
NICHOLSON, GEORGE T., MD FAAFP 33 ACT FP
PO BOX 147, CORNELIA 30531
SWAIN, BRUCE 33 ACT FP
CLARKESVILLE 30523
THAKRAR, B.D. 33 ACT GS
PO BOX 307, DEMOREST 30535
THAKRAR, CHANDRIKA B. 33 ACT AN
PO BOX 307, DEMOREST 30535
WARE, CHARLES I. 33 ACT GYN
PO BOX G, CLARKSVILLE 30523
WATERS, LAMAR H. 33 ACT IM
BOX 228, CLARKESVILLE 30523

34—HALL

ACREE, JOHN W. 34 ACT FP
2 HOSPITAL ST, HIAWASSEE 30546
AGRIN, ALFRED 34 A P
NORTH GA MH-MR CENTER, GAINESVILLE 30501
ALDAY, JAMES M., JR. 34 ACT ORS
650 BROAD ST SE, GAINESVILLE 30505
ALLEN, CALVIN F., JR. 34 ACT AN
743 SPRING ST, GAINESVILLE 30505
ANDERSON, ROBERT H., JR. 34 ACT GS
194 GOLD ST, GAINESVILLE 30501
ASKEW, DANNY E. 34 ACT OBG
1211 SHERWOOD PARK DR, GAINESVILLE 30501
BATES, JACK M. 34 ACT P
664 LANIER PARK DR, GAINESVILLE 30505
BISHKO, JAY R. 34 ACT AN
PO BOX 2979, GAINESVILLE 30503
BLACK, WILEY S. 34 ACT GS
669 LANIER PARK DR NE, GAINESVILLE 30505
BLACKSHEAR, STUART G. 34 ACT GS
669 LANIER PARK DR NE, GAINESVILLE 30505
BLOODWORTH, A. FREDERICK 34 ACT IM
1098 SOUTH ENOTA DR NE, GAINESVILLE 30505
BRADLEY, CHARLES K. 34 ACT OPH
PO BOX 657, GAINESVILLE 30503
BRANCH, CLINTDN E., JR. 34 ACT N
290 SOUTH ENOTA DR, GAINESVILLE 30501
BROWN, THOMAS D., JR. 34 ACT OTO
304 ENOTA DR NE, GAINESVILLE 30505
BROWNING, JDHN W. 34 ACT OBG
1211 SHERWOOD PARK DR, GAINESVILLE 30501
BURNS, JAMES R., JR. 34 ACT GP
700 SOUTH ENOTA DR NE, GAINESVILLE 30505
BURNS, JOHN A. 34 ACT AN
NE GEORGIA MED CENTER, GAINESVILLE 30501
BURNS, JDHN KNOX, III 34 ACT OBG
1100 VINE ST, GAINESVILLE 30505
BUTTS, JAMES A. 34 ACT IM
710 BROAD ST SE, GAINESVILLE 30501
CALLAHAN, WILLIAM THDMAS 34 ACT GE
710 BROAD ST SE, GAINESVILLE 30501
DARDEN, JOHN W. 34 ACT GS
669 LANIER PARK DR NE, GAINESVILLE 30505
DEDONIS, JAMES L. 34 ACT IM,CD
667 LANIER PARK DR, GAINESVILLE 30501
DIXON, P.K. 34 ACT GS
669 LANIER PARK DR NE, GAINESVILLE 30505
DIXON, PIERCE K., III 34 ACT GS
669 LANIER PARK DR, GAINESVILLE 30505
DURISCH, LAWRENCE L. 34 ACT OTO
304 ENOTA DR, GAINESVILLE 30505
EASLEY, PAUL E. 34 ACT AN
PO BOX 2979, GAINESVILLE 30503
EITH, RONALD E. 34 ACT A
1235 SPRING ST NE, GAINESVILLE 30501
ESTES, EDWARD E., JR. 34 ACT U
1114 VINE ST, GAINESVILLE 30505
FARKAS, STEPHEN J. 34 ACT OPH
664 LANIER PARK DR NE, GAINESVILLE 30501
FERGUSON, ROBERT C. 34 ACT CD,IM
710 BROAD ST SE, GAINESVILLE 30501
FERRELL, WILLIAM C. 34 ACT R
745 SPRING ST, GAINESVILLE 30505
FORREST, JOHN W. 34 ACT OPH
1128 VINE ST, GAINESVILLE 30505
FRENCH, JAMES B. 34 ACT OBG
660-E LANIER PARK DR NE, GAINESVILLE 30505
GARLAND, JOHN W., III 34 ACT P
664 LANIER PARK DR NE, GAINESVILLE 30505
GARNER, W.R. 34 ACT IM
RTE 12 BOX 163-1, GAINESVILLE 30501
GEIGER, C. LEDNARD 34 ACT PTH
PO BOX 1354, GAINESVILLE 30505
GHENT, OLIVER T. 34 ACT R
510 FORREST AVE NW, GAINESVILLE 30501
GOTAY, HECTOR 34 ACT N
592 MEDICAL PARK DR, GAINESVILLE 30501
GOWDER, GEORGE D., JR. 34 ACT FP
PO BOX 726, BLAIRSVILLE 30512
GRANT, ROBERT C. 34 ACT IM
174 PRIOR ST NE, GAINESVILLE 30501
GUNN, JOSEPH B. 34 ACT PD
247 SOUTH ENOTA DR, GAINESVILLE 30505
HARDMAN, BILLY S. 34 ACT GYN
420 BROAD ST SE, GAINESVILLE 30501
HEMMER, JOHN L., JR. 34 ACT ORS
660-A LANIER PARK DR NE, GAINESVILLE 30505
HILL, J. WAYNE 34 ACT OBG
1100 VINE ST, GAINESVILLE 30501
HOPKINS, RALPH D. 34 ACT R
743 SPRING ST, GAINESVILLE 30505
HDSFORD, J. MICHAEL 34 ACT PD
1220 SHERWOOD PARK DR, GAINESVILLE 30501
HOTHEM, ARDEN LUTHER 34 ACT PS
1224 SHERWOOD PARK DR NE, GAINESVILLE 30501
JACKSON, BILLY JOE 34 ACT AN
743 SPRING ST, GAINESVILLE 30505
JENKINS, W. THOMAS 34 ACT OBG
1211 SHERWOOD PARK DR, GAINESVILLE 30501
JENNINGS, HENRY S., JR. 34 ACT IM
710 BROAD ST SE, GAINESVILLE 30501
JOHNSON, ALLYN C., JR. 34 ACT IM
1144 VINE ST NE, GAINESVILLE 30501
JOHNSDN, GEORGE C. 34 ACT P
660-C LANIER PARK DR, GAINESVILLE 30505
JOINER, HARTWELL 34 ACT IM
319 NORTH BRADFORD ST, GAINESVILLE 30501
JONES, CHARLES L. 34 ACT PD
274 ENOTA DR NE, GAINESVILLE 30505
JONES, WILLIAM B. 34 ACT U
660-G LANIER PARK DR NE, GAINESVILLE 30501
JDNES, WILLIAM T. 34 ACT GP
404 GREEN ST NE, GAINESVILLE 30501
JORDAN, TOMMY H. 34 ACT P
664 LANIER PARK DR NE, GAINESVILLE 30505
KEENER, ELLIS B. 34 ACT NS
434 ACADEMY ST NE, GAINESVILLE 30501
KEITH, THOMAS L. 34 ACT AN
743 SPRING ST, GAINESVILLE 30505
KELLEY, CHARLES N. 34 ACT IM
710 BROAD ST, GAINESVILLE 30501
LAKE, FRANK G., III 34 ACT TR
147 OVERLOOK DR, GAINESVILLE 30505
LANGSTON, WILLIAM T. 34 ACT PD
650 BROAD ST SE, GAINESVILLE 30505
LEIGH, JAMES H., JR. 34 ACT GS
194 GOLD ST, GAINESVILLE 30505
LITTLE, CHARLES H. 34 ACT ORS
700 SOUTH ENOTA DR NE, GAINESVILLE 30501
LYKINS, LAWRENCE E. 34 ACT U
1114 VINE ST NE, GAINESVILLE 30505
LYNCH, EDWIN H. 34 ACT OBG
1100 VINE ST, GAINESVILLE 30501
MANUS, WILLIAM A. 34 ACT FP
668 LANIER PARK DR NE, GAINESVILLE 30501
MARASCALCO, ROBERT J. 34 ACT ORS
660-A LANIER PARK DR NE, GAINESVILLE 30505
MARTIN, LEE A. 34 ACT U
1114 VINE ST NE, GAINESVILLE 30505
MARTIN, RDGER P. 34 ACT OBG
254 SOUTH ENOTA DR, GAINESVILLE 30501
MCALISTER, BRADWELL R. 34 ACT ORS
650 BROAD ST SE, GAINESVILLE 30505
MCCARVER, W.C., JR. 34 ACT FP
200 PRIOR ST SE, GAINESVILLE 30501
MCCRUM, B.A. 34 ACT GYN
420 BROAD ST, GAINESVILLE 30501
MODRE, F. STEPHEN 34 ACT IM
660-F LANIER PARK DR, GAINESVILLE 30501
MDRRIS, LARRY A. 34 ACT PD
650 BROAD ST SE, GAINESVILLE 30505
MURRAY, HAMIL 34 ACT PTH
743 SPRING ST, GAINESVILLE 30505
NEWMAN, HARVEY M. 34 ACT PD
650 BROAD ST SE, GAINESVILLE 30505
NICHOLSDN, W. LANIER 34 ACT FP
2 HOSPITAL ST, HIAWASSEE 30546
DWENS, ROGER D. 34 ACT IM
667 LANIER PARK DR NE, GAINESVILLE 30505
PARKS, JAMES F. 34 ACT IM
667 LANIER PARK DR NE, GAINESVILLE 30505
PEACOCK, RAY L., JR. 34 ACT PD
274 ENOTA DR NE, GAINESVILLE 30505
POOL, LELAND L. 34 ACT AN
743 SPRING ST, GAINESVILLE 30505
POOLE, SAMUEL O. 34 ACT IM
710 BROAD ST SE, GAINESVILLE 30501
PROCTDR, RDBERT F. 34 ACT IM
660-I LANIER PARK DR NE, GAINESVILLE 30505
PYBURN, RDBIN R. 34 ACT IM
660-H LANIER PARK DR, GAINESVILLE 30501

RABB, FORTE C. 34 ACT D
327 NORTHSIDE DR NW, GAINESVILLE 30501
RANGE, JDHN N. 34 ACT GP
RTE 2 BOX 8, OAKWOOD 30566
RAUCH, SAMUEL DEAN 34 ACT IM
710 BROAD ST, GAINESVILLE 30501
REED, JOHN H., JR. 34 ACT OPH
1128 VINE ST NE, GAINESVILLE 30505
RICHARDSON, RUSSELL E. 34 ACT FP
700 SOUTH ENOTA DR NE, GAINESVILLE 30505
RIGEL, EDWARD PAUL 34 ACT AN
743 SPRING ST, GAINESVILLE 30505
ROBINSON, THEODDRE RODNEY 34 ACT OM
PO BOX 2537, GAINESVILLE 30501
SILVER, JEROME I. 34 ACT R
11585 ALPHARETTA ST, ROSWELL 30076
SMITH, GREGORY VINCENT 34 ACT PD
1208 SHERWOOD PARK NE, GAINESVILLE 30501
SMITH, MARTIN H. 34 ACT PD
274 ENOTA DR NE, GAINESVILLE 30505
SMITH, RODNEY L. 34 ACT PTH
743 SPRING ST, GAINESVILLE 30505
SPEAR, J. LOUIS 34 ACT R
2354 ISLAND DR NE, GAINESVILLE 30501
STAFFORD, CHARLES R. 34 ACT
254 SOUTH ENOTA DR, GAINESVILLE 30501
STEPHENS, MARVIN R. 34 ACT AN
743 SPRING ST, GAINESVILLE 30505
STEWART, RICHARD M. 34 ACT IM
660-B LANIER PARK DR NE, GAINESVILLE 30501
STRIBLING, WARREN D. 34 ACT IM
710 BROAD ST SE, GAINESVILLE 30501
STRITTMATTER, JAMES C. 34 ACT R,NM
PO BOX 2417, GAINESVILLE 30503
TAYLOR, CHARLES D. 34 ACT IM
710 BROAD ST SE, GAINESVILLE 30501
TETHER, ROBERT S. 34 ACT GS
194 GOLD ST NE, GAINESVILLE 30505
THOMAS, FRED B., JR. 34 ACT PS
1224 SHERWOOD PARK DR NE, GAINESVILLE 30501
THOMPSON, W. JACKSON 34 ACT GYN
1144 VINE ST NE, GAINESVILLE 30505
VALENTINE, H.E., JR. 34 ACT IM
429 SPRING ST SE, GAINESVILLE 30501
WALKER, C.J., JR. 34 ACT FP
242 ENOTA DR NE, GAINESVILLE 30505
WARD, EUGENE L. 34 ACT OTO
PO BOX 13, GAINESVILLE 30503
WESTFALL, DAVID N. 34 ACT FP
668 LANIER PARK DR NE, GAINESVILLE 30501
WHITE, WILLIAM H., JR. 34 ACT OBG
1100 VINE ST NE, GAINESVILLE 30505
WHITMIRE, RONALD N. 34 ACT OTO
660-D LANIER PARK DR, GAINESVILLE 30505
WHITWORTH, C.W. 34 ACT OTO
PO BOX 315, GAINESVILLE 30503
WILLERS, DONALD R. 34 ACT ORS
650 BROAD ST SE, GAINESVILLE 30505
WRIGHT, ASBURY D., JR. 34 ACT D
327 NORTHSIDE DR NW, GAINESVILLE 30501
WRIGHT, J. RDBERT 34 ACT OPH
295 WISTERIA DR, GAINESVILLE 30501
ZDERCHER, PHILIP 34 ACT OTO
304 SOUTH ENOTA DR NE, GAINESVILLE 30505

35—HART

CACCHIOLI, LOUIS G. 35 ACT FP
202 WEST HOWELL ST, HARTWELL 30643
DAVIS, BILLY J. 35 ACT FP
GIBSON ST, HARTWELL 30643
MERRILL, JONATHAN R. 35 ACT GS
117 ATHENS ST, HARTWELL 30643
WILLIAMS, JOHN W., JR. 35 ACT FP
47 AUGUSTA RD, LAVONIA 30553
WYSDNG, EDWARD DALE 35 ACT FP
113 ATHENS ST, HARTWELL 30643

36—PEACH BELT

ARNALL, JOHN ROBERT 36 ACT FP
PO DRAWER G, PERRY 31069
BEARD, CARL L. 36 R OBG
123 TANGLEWOOD DR, WARNER ROBINS 31093
BOHANAN, G. WAYNE 36 ACT R
102 HOSPITAL DR, WARNER ROBINS 31093
BDOTLE, WILLIAM A., JR. 36 ACT R
HOUSTON CO HOSPITAL, WARNER ROBINS 31093
BRAHN, GEORGE R. 36 ACT GS
105-B BRIARCLIFF, WARNER ROBINS 31093
BROWN, ELBERT H. 36 ACT FP
1015 NORTH HOUSTON RD, WARNER ROBINS 31093
CABASARES, HORATIO V. 36 ACT GS
1057 MORNINGSIDE DR, PERRY 31069
CALLAHAN, DAN 36 ACT
134 HOSPITAL DR, WARNER ROBINS 31093
CARTER, ROBERT A. 36 ACT GP
PO BOX 2201, WARNER ROBINS 31093
CRAWFORD, CARL L. 36 ACT FP
1410 RUSSELL PKY, WARNER ROBINS 31056
CULVERN, ROBERT S. 36 ACT OBG
100 DONNA KAY DR, BONAIRE 31005
DUDNEY, WILLIAM C. 36 ACT P
1017 NORTH HOUSTON RD, WARNER ROBINS 31093
DUKE, JDHN F., III 36 ACT FP
PO BOX 1088, FORT VALLEY 31030
DUNN, JAMES R., JR. 36 S GS
ROBINS AFB, WARNER ROBINS 31098
ENGLISH, INMAN C. 36 ACT PD
116 SOUTH HOUSTON RD, WARNER ROBINS 31093
ETCHASON, GREGORY J. 36 ACT IM
PO BOX 1435, FORT VALLEY 31030
FUSSELL, DANIEL O. 36 ACT IM
1540 WATSON BLVD, WARNER ROBINS 31093
GAYTON, JOHNNY L. 36 ACT OPH
216 CORDER RD, WARNER ROBINS 31093
GRANTHAM, V.J. 36 ACT FP
PO BOX 1088, FORT VALLEY 31030
GUZZARDO, MARCIA B. 36 ACT PD
116 SOUTH HOUSTON RD, WARNER ROBINS 31093
HARVEY, DAVID N., III 36 ACT PD
116 SOUTH HOUSTON RD, WARNER ROBINS 31093
HENDRICK, A.G. 36 ACT FP
BOX 32, PERRY 31069
HERNANDEZ, FERNANDD G. 36 ACT IM
1011 NORTH HOUSTON RD, WARNER ROBINS 31093
HOPKINS, MARK D. 36 S
APT G-16 CASTAWAYS, WARNER ROBINS 31093
IVEY, C. RAY, JR. 36 ACT FP
1554 WATSON BLVD, WARNER ROBINS 31093
JAYARAJ, HARIYEBBE C. 36 ACT IM
1043 NORTH HOUSTON RD, WARNER ROBINS 31093
LUCAS, WALLACE 36 ACT FP
613 E DYKES ST, COCHRAN 31014
MANNING, JDHANN R. 36 ACT OBG
105 BRIARCLIFF RD, WARNER ROBINS 31093
MARSHALL, A. SMDAK 36 ACT GS
725 NORTH CAMELLIA BLVD, FORT VALLEY 31030
MCEVER, VIRGLE W., JR. 36 ACT GS
105-B BRIARCLIFF, WARNER ROBINS 31093
MELVIN, PERRY D. 36 ACT FP
110 HOSPITAL DR, WARNER ROBINS 31093
MESERVE, FRANCIS BRUCE 36 ACT GP
121 NORTH DAVIS DR, WARNER ROBINS 31093
MOOSAJEE, RAZIUDIN Y. 36 ACT PD
1049 NORTH HOUSTON RD, WARNER ROBINS 31093
MYERS, B. RHETT 36 ACT P
624 NEW ST, MACON 31201
NATHAN, DANIEL E. 36 ACT FP
PO BOX 1179, FORT VALLEY 31030
NAVARRO, ALFDNSO V. 36 S IM
ROBINS AIR FORCE BASE, WARNER ROBINS 31098
PARKER, FRANK M. 36 ACT OBG
105 BRIARCLIFF RD, WARNER ROBINS 31093
PILCHER, B. LAMAR 36 ACT R
PO BOX 2886, WARNER ROBINS 31093
RAGHU, G.V. 36 ACT OBG
PO BOX 2105, WARNER ROBINS 31099
RAYNOR, L. KENNETH, JR. 36 ACT OBG
PO BOX 2546, WARNER ROBINS 31093
SALEHBHAI, MANSOOR 36 ACT PD
1049 NORTH HOUSTON RD, WARNER ROBINS 31093
SAMPSDN, BRUCE D. 36 ACT IM
1019 KEITH DR, PERRY 31069
SAMS, FRANK H., JR. 36 ACT FP
BOX 536, REYNOLDS 31076
SANDERS, F. HUNT 36 ACT AN
PO BOX 2605, WARNER ROBINS 31093
SEVERS, RONALD G. 36 ACT GS
105-B BRIARCLIFF, WARNER ROBINS 31093
SIMS, HARRY EDWARD 36 ACT
PO BOX 955, FT VALLEY 31030
SPEARS, WENTFORD A. 36 ACT OTO
212 HOSPITAL DR STE C, WARNER ROBINS 31093
SPIVEY, JAMES W. 36 ACT ORS
124 HOSPITAL DR, WARNER ROBINS 31093
SPIVEY, JIMMY A. 36 ACT ORS
124 HOSPITAL DR, WARNER ROBINS 31056
STRICKLAND, W.E. 36 ACT OBG
1119 MORNINGSIDE DR, PERRY 31069
STRUTH, ALAN G. 36 ACT IM
PO BOX 2405, WARNER ROBINS 31093
SUGRUE, MARJORIE L. 36 ACT GP
105 CALLE VERDE, WARNER ROBINS 31093
VANCE, LUTHER, JR. 36 ACT FP
1057 MORNINGSIDE DR, PERRY 31069
VECCHIO, JOHN J. 36 ACT U
212 HOSPITAL DR, WARNER ROBINS 31093
VINSON, FRANK 36 ACT FP
725 NORTH MACON ST, FORT VALLEY 31030
WEBB, H. MICHAEL 36 ACT EM
BOX 2886, WARNER ROBINS 31093
WEEMS, H.E., JR. 36 ACT FP
PO DRAWER G, PERRY 31069
WHATLEY, E.C. 36 ACT GP
PO BOX 367, REYNOLDS 31076
WHITAKER, JAMES Q. 36 ACT PTH
PO BOX 2343, WARNER ROBINS 31099
WDRSLEY, NDRMAN E., II 36 ACT AN
416 LAKE FRONT DR, WARNER ROBINS 31093
WYNNE, MORGAN D., JR. 36 ACT PD
116 SOUTH HOUSTON RD, WARNER ROBINS 31093

37—JACKSON-BANKS

ALEXANDER, MANUEL 37 ACT ORS
94 HOSPITAL RD, COMMERCE 30529
ALEXANDER, SUSAN 37 ACT OBG
94 HOSPITAL RD, COMMERCE 30529
ALLEN-DALRYMPLE, BARBARA J. 37 ACT OBG
HOSPITAL RD, COMMERCE 30529
GRIFFETH, JDE L. 37 ACT FP,GS
MEDICAL CENTER CLINIC, COMMERCE 30529
ROGERS, A.A., JR. 37 R FP
11 NORTH ELM ST, COMMERCE 30529
SERGENT, PAUL M. 37 ACT FP
335 SOUTH BROAD ST, COMMERCE 30529
SHETTY, NARAYAN SESU 37 ACT PD
92 HOSPITAL RD, COMMERCE 30529
TURK, L.N., JR. 37 ACT GS
PO BOX 52, HOMER 30547
VICKERY, S.A. 37 ACT FP
259 NORTH ELM ST, COMMERCE 30529

38—HENRY

ALONSO, KENNETH B. 38 ACT PTH
2921 MARGARET MITCHELL CT NW, ATLANTA 30327
BLISSIT, JOSEPH A. 38 ACT IM
175 DECATUR RD, MCDONOUGH 30253
ESCALERA, GUSTAVO A. 38 ACT GS
STE 9 HENRY PROF BLDG, STOCKBRIDGE 30281
FOSTER, GURDON R., JR. 38 ACT FP
55 SIMS ST, MCDONOUGH 30253
MUHANNA, SHAJIH 38 ACT CDS
150 MEDICAL WAY STE 3-1, RIVERDALE 30274
PODOBNIKAR, MICHAEL F. 38 ACT GS
PO BOX 335, STOCKBRIDGE 30281
SOUZA, RENATO C. 38 ACT EM
274 SENOIA RD, FAIRBURN 30213
TEKIN, MAHIR 38 ACT AN
490 WEST PACES FERRY RD NW, ATLANTA 30305

39—JEFFERSON

GILMORE, THOMAS W., JR. 39 ACT IM
1200 PEACHTREE ST, LOUISVILLE 30434
POLHILL, JAMES B. 39 ACT FP
JEFFERSON HOSPITAL, LOUISVILLE 30434
REVELL, WALTER J. 39 ACT FP
PO BOX 5, LOUISVILLE 30434
WEISSMAN, EVELYN L. 39 ACT GS
1067 PEACHTREE ST, LOUISVILLE 30434
WEISSMAN, IRA M. 39 ACT PD
1067 PEACHTREE ST, LOUISVILLE 30434
WILLIAMS, CHARLES ROY 39 R FP
126 NORTH MAIN ST, WADLEY 30477
YUN, IN W. 39 ACT FP
809 ESTELLE ST, WRENS 30833

42—LAURENS

AVERA, BERTRAM PRICE, JR. 42 R IM
302 STONE ST, WRENS 30833
BEDINGFIELD, CARL O. 42 ACT PD
306 WEST GAINES ST, DUBLIN 31021
BELL, J.A., JR. 42 ACT FP
DUBLIN MEDICAL ARTS CENTER, DUBLIN 31021
BUSH, JAMES L. 42 R OPH,OTO
RTE 3 BOX 293, DUBLIN 31021
CABRERA-CICERO, ORLANDO 42 S GS
VA CENTER, DUBLIN 31021
CAMPBELL, CLARENCE G., JR 42 ACT R
PO BOX 793, DUBLIN 31021
CARRUTH, JOSEPH E. 42 ACT CD,IM
606 ACADEMY AVE, DUBLIN 31021
CARSWELL, NELSON S., JR. 42 ACT PD
MEDICAL ARTS CENTER, DUBLIN 31021
CHISM, NEWTON W., JR. 42 ACT OBG
ERIN OFFICE PARK, DUBLIN 31021
CHUNG, SOONG PYO 42 ACT PTH
VA CENTER, DUBLIN 31021
COLEMAN, FRED J. 42 R FP
1616 BELLEVUE RD, DUBLIN 31021
DANIELL, DUREN 42 ACT ORS
PO BOX 1687, DUBLIN 31040
DAVIS, LAWTON C. 42 ACT IM
606 ACADEMY AVE, DUBLIN 31021
DODD, WILLIAM ASA 42 ACT FP
PO BOX 257, WRIGHTSVILLE 31096
DUPREE, J.T. 42 S GS
VA CENTER, DUBLIN 31021
EVANS, GEDRGE H. 42 ACT U
ERIN PARK, DUBLIN 31021
FERNANDEZ, B.P. 42 ACT IM
8473 BRIARWOOD RD, JACKSONVILLE FL 32217
FITZGERALD, EDMUND M., JR. 42 S IM
VA CENTER, DUBLIN 31021
GARNER, STEVEN R. 42 ACT FP
MEDICAL CENTER, DUBLIN 31021
GLOVER, RIDLEY M. 42 ACT R
PO BOX 793, DUBLIN 31040
HEARD, WILLIAM C. 42 ACT OTO
ERIN OFFICE PK #22, DUBLIN 31021
HOFFA, DANNY E. 42 ACT PTH
FAIRVIEW PARK HOSPITAL, DUBLIN 31021
JOHNSON, GRADY H. 42 ACT FP
112 ROWE ST, DUBLIN 31021
JOHNSON, OTTO B., JR. 42 ACT IM
606 ACADEMY AVE, DUBLIN 31021
JONES, JAMES YOUNG 42 ACT OPH
BELLEVUE RD, DUBLIN 31021
KAVURI, SURENDRANATH 42 ACT PD
112 ROWE ST, DUBLIN 31021
KIBLER, JAMES A. 42 ACT P
309 BELLEVUE, DUBLIN 31021
KIM, SOON OK 42 ACT OBG
107 VERNON ST, DUBLIN 31021
KIRKLAND, JAMES J. 42 ACT FP
MEDICAL CENTER, DUBLIN 31021
LANGFORD, R. ALAN 42 ACT D
BELLEVUE RD, DUBLIN 31021
LONGINO, GRADY E. 42 ACT IM
VA CENTER, DUBLIN 31021
MANN, FRANK R., JR. 42 ACT GP
TELFAIR MEDICAL GROUP, MCRAE 31055
MCNATT, EUGENE N. 42 ACT PTH
FAIRVIEW PARK HOSPITAL, DUBLIN 31021
MORTON, JOHN B. 42 ACT IM
PO BOX 486, GRAY 31032
O'DANIEL, J.F. 42 R FP
107 ROWE ST, DUBLIN 31021
OLIVER, ROBERT W., JR. 42 ACT GS
508 ACADEMY AVE, DUBLIN 31021
OTTS, JOHN C. 42 ACT FP
ERIN OFFICE PARK, DUBLIN 31021
PATEL, KANTILAL L. 42 ACT IM
106 ROWE ST, DUBLIN 31021
PATEL, PANKAJ T. 42 S R
VA MEDICAL CENTER, DUBLIN 31021
PRADA, OSCAR 42 ACT FP
204 BROOKWOOD DR, DUBLIN 31021
PRADHAN, MEDHA A. 42 ACT AN
DUBLIN VA MEDICAL CENTER, DUBLIN 31021
PRICE, QUENTIN 42 ACT FP
205 WEST GAINES ST, DUBLIN 31021
PRINE, JOE R. 42 ACT OTO
KELLAM RD, DUBLIN 31021
RAILA, FRANK ARTHUR 42 S R
VA MEDICAL CENTER, AUGUSTA 30910
RAO, SANTEEV H.V. 42 ACT IM
VA MEDICAL CENTER, DUBLIN 31021
REDDY, SUJATHA K. 42 ACT P
309 ST FRANCIS PL, DUBLIN 31021
REEVES, SEAB E.A. 42 R AN
PO BOX 1426, DUBLIN 31021
RICKNER, THOMAS W. 42 ACT U
2406 BELLEVUE RD, DUBLIN 31021
ROCHE, WILLIAM P., JR. 42 ACT IM
606 ACADEMY AVE, DUBLIN 31021
ROWLAND, J. ROY, JR. 42 ACT FP
MEDICAL CENTER, DUBLIN 31021
SATHE, ANAND J. 42 ACT OBG
107 VERNON ST, DUBLIN 31021
SHUMAN, MONTY B. 42 ACT FP
MEDICAL CENTER, DUBLIN 31021
SHUMAN, RDBERT D. 42 ACT IM
606 ACADEMY AVE, DUBLIN 31021
SKINNER, JDHN J., JR. 42 R IM
606 ACADEMY AVE, DUBLIN 31021
SMITH, F.A., JR. 42 ACT FP
PO BOX 477, MCRAE 31055
SMITH, JAMES E. 42 ACT GS
508 ACADEMY AVE, DUBLIN 31021
SMITH, MALCOLM M. 42 ACT FP
PO BOX 115, MCRAE 31055
SMITH, ROGER D. 42 ACT OPH
BELLEVUE RD, DUBLIN 31021
STAPLETON, JAMES W. 42 S ORS
2309 SCOTT DR, DUBLIN 31021
TANNER, GEORGE E. 42 ACT GS
ERIN OFFICE PARK, DUBLIN 31021

43—LUMPKIN

BEHRMANN, PAUL J. 43 ACT FP
HWY 53 WEST, DAWSONVILLE 30534
CAUSEY, DAVID A. 43 ACT R
LUMPKIN COUNTY HOSPITAL, DAHLONEGA 30533
GILL, SURINDER P.S. 43 ACT R
LUMPKIN COUNTY HOSPITAL, DAHLONEGA 30533
GUZMAN, MARGARITA 43 ACT GS
PO BOX 777, DAHLONEGA 30533
HARVEY, JAMES S. 43 ACT FP
403 HAWKINS ST, DAHLONEGA 30533
LONG, HAROLD G. 43 ACT GP
PO BOX 186, DAHLONEGA 30533
SEBAS, JOHN A. 43 ACT FP
PO BOX 262, DAWSONVILLE 30534
WHERRY, RICHARD A. 43 ACT FP
96 MEMORIAL DR, DAHLONEGA 30533

44—MC DUFFIE

AVERITT, THOMAS E. 44 R FP
PO BOX 897, THOMSON 30824
LEMLEY, JOHN W. 44 ACT FP
PO BOX 300, THOMSON 30824
POWELL, MICHAEL F. 44 ACT IM
604 WARE ST, THOMSON 30824
VAUGHAN, W.L. 44 ACT GS
PO BOX 1076, THOMSON 30824

45—MERIWETHER-HARRIS-TALBOT

BAILEY, ANN A. 45 ACT OS
GA WARM SPRINGS HOSP, WARM SPRINGS 31830
CHAMBLESS, MIRIAM WALKER 45 ACT FP
PO BOX 345, HAMILTON 31811
CHAMBLESS, WILLIAM G. 45 R FP
PO BOX 345, HAMILTON 31811
COLLINS, JAMES E. 45 ACT FP
129 EAST SECOND ST, MANCHESTER 31816
DUNLAP, ERNEST B., JR. 45 R ORS
12 EAST THIRD ST, MANCHESTER 31816
JACKSON, HENRY C. 45 ACT FP
PO BOX 308, MANCHESTER 31816
KNOWLES, JAMES B. 45 ACT PM
PO BOX 130, WARM SPRINGS 31830
RAPER, HAL STUART 45 R US
THE FOUNDATION, WARM SPRINGS 31830
SMITH, JAMES W. 45 ACT FP
129 EAST SECOND ST, MANCHESTER 31816
WASDEN, HOWELL A. 45 ACT FP
BOX 447, WARM SPRINGS 31830
WHITWORTH, JACK W. 45 R FP
1901 NORTH SECOND CT, LANETT AL 36863

46—MITCHELL

ARWOOD, WILLIAM C., JR. 46 ACT FP
HAND AVE, PELHAM 31779
BRASWELL, HAROLD M. 46 S AM
PO BOX 469, CAMILLA 31730
CHAO, STEPHEN C. 46 ACT OBG
16606 PARK LANE PL, LOS ANGELES CA 90049

DOYLE, JDSEPH P., JR. 46 ACT FP
PO BOX 520, CRAWFORDVILLE FL 32327
MAGAT, A.B., JR. 46 ACT GS
24 SOUTH ELLIS ST, CAMILLA 31730
MCNEILL, A.A., JR. 46 ACT FP
PO BOX 389, CAMILLA 31730
SHIVER, R.B., JR. 46 ACT FP
25 PERRY ST, CAMILLA 31730

47—MUSCOGEE

ADAMS, WILLIAM E. 47 ACT N
2119 WARM SPRINGS RD, COLUMBUS 31904
ADAMSON, JAMES W. 47 S IM
MARTIN ARMY HOSPITAL, FT BENNING 31905
AGRAWAL, BIPIN 47 ACT IM,NEP
401 DOCTORS BLDG, COLUMBUS 31901
AICHER, JOHN A. 47 I&R
PO BOX 951, COLUMBUS 31994
ALFORD, TIM J. 47 I&R
PO BOX 951, COLUMBUS 31994
ALMONTE, ILDEFDNSO G.D. 47 A DR
1901 LANCASTER DR, COLUMBUS 31904
ALVAREZ, ANGEL C. 47 ACT PD
713 20TH ST, COLUMBUS 31904
AMDS, WILLIAM L., JR. 47 ACT OBG
2022 10TH AVE, COLUMBUS 31901
ANDREWS, JAMES R. 47 ACT ORS
6262 HAMILTON RD, COLUMBUS 31904
ARANAS, CATALINA T. 47 ACT OBG
217 DOCTORS BLDG, COLUMBUS 31901
ARANAS, TEOFREDO C. 47 A DR
6925 SPRING LAKE DR, COLUMBUS 31904
AUGUST, GARRY LEWIS 47 ACT IM
500 18TH ST STE B-50, COLUMBUS 31901
AVERETT, JACK M., JR. 47 ACT IM
2300 MANCHESTER EXPY, COLUMBUS 31904
BAKER, CHAMP L., JR. 47 ACT ORS
6262 HAMILTON RD, COLUMBUS 31904
BALDWIN, B. CARTER 47 ACT D
3408 CODY RD, COLUMBUS 31907
BASSETT, WILBUR B., JR. 47 ACT IM
615 - 19TH ST, COLUMBUS 31901
BEACH, BESSIE MAE 47 ACT PD
17 BALENTINE DR, GREENVILLE SC 29605
BELEN, RUBEN B. 47 ACT EM
6101 GARRET RD, MIDLAND 31820
BERENSON, MORTON P. 47 ACT IM
1905 SEVENTH AVE, COLUMBUS 31901
BERMAN, DAVE 47 ACT D
1918 COUNTRY CLUB RD, COLUMBUS 31906
BICKERSTAFF, HUGH J. 47 ACT OBG
2228 WILDWOOD, COLUMBUS 31906
BLAKE, GREGORY H. 47 S FP
MARTIN ARMY HOSP, FORT BENNING 31905
BLALOCK, JACK H., JR. 47 ACT IM
2300 MANCHESTER EXPY, F-1, COLUMBUS 31904
BOYTER, HENRY H. 47 ACT OBG
116 DOCTORS BLDG, COLUMBUS 31901
BRACKETT, MICHAEL L. 47 I&R
PO BOX 951, COLUMBUS 31994
BREEDLOVE, WILLIAM D. 47 I&R
PO BOX 951, COLUMBUS 31994
BREWER, PHILIP L. 47 ACT CDS
201 PHYSICIANS BLDG, COLUMBUS 31901
BRIGHTWELL, LARRY 47 ACT GS
PO BOX 6829, COLUMBUS 31907
BRILL, HARRY H., JR. 47 ACT IM
1905-C SEVENTH AVE, COLUMBUS 31901
BRISTER, MARILYN R. 47 I&R FP
PO BOX 951, COLUMBUS 31902
BROCATO, SIMONE 47 ACT CD
ST FRANCIS MEDICAL PK 'F 3, COLUMBUS 31904
BURDETTE, FRED M. 47 ACT CDS
201 PHYSICIANS BLDG, COLUMBUS 31901
BURR, MAX E. 47 ACT ORS
6262 HAMILTON RD, COLUMBUS 31904
BUSH, JDHN 47 ACT FP
PO BOX 213, PHENIX CITY AL 36867
BUTLER, CLARENCE 47 ACT IM
PO BOX 7000, COLUMBUS 31995
CALHDUN, CHARLES L. 47 ACT OPH
PO BOX 4276, COLUMBUS 31995
CAMP, LEAH R. 47 ACT PH
PO BOX 2299, COLUMBUS 31993
CARPENTER, RDBERT H. 47 ACT OBG
2404 13TH ST, COLUMBUS 31906
CARR, J. BRUCE 47 ACT NEP
2300 MANCHESTER EXPY, COLUMBUS 31904
CARROLL, CHERYL A. 47 ACT NPM
1968 NORTH AVE, COLUMBUS 31995
CARROLL, H. BANKS 47 ACT FP
2100 NORTH AVENUE, COLUMBUS 31904
CELESTINO, FRANK S. 47 DE4 FP
MARTIN ARMY HOSPITAL, FORT BENNING 31905
CHASE, JERRY S. 47 ACT FP
2121 WARM SPRINGS RD, COLUMBUS 31995
CHASTAIN, J.B. 47 ACT PD
1710 HILTON AVE, COLUMBUS 31906
CHHOKAR, BALBIR S. 47 ACT OPH
711 CENTER ST, COLUMBUS 31904
CHHOKAR, RAJINDER 47 ACT IM,CD
711 CENTER ST, COLUMBUS 31901
CHIPMAN, R.A. 47 ACT FP
PHYSICIANS BLDG, COLUMBUS 31901
CLEPPER, ALAN S. 47 ACT PTH
PO BOX 4176, COLUMBUS 31902
COCHRAN, THOMAS A., JR. 47 ACT PS
2200 NORTH AVE, COLUMBUS 31904
CDHEN, MARVYN D. 47 ACT PD,AL
1968 NORTH AVE, COLUMBUS 31901
CONE, TERRY A. 47 I&R
PO BOX 951, COLUMBUS 31994
CONGER, A.B. 47 ACT GS
206 DOCTORS BLDG, COLUMBUS 31901
CONN, LEE R.M. 47 ACT GP
1305 FOREST AVE, COLUMBUS 31906
CONNELLY, JDHN C. 47 ACT P
2000 16TH AVE, COLUMBUS 31993
CDNNER, GEDRGE R. 47 ACT GP
920 - 18TH ST, COLUMBUS 31993
CROSSE, JAMES E.W. 47 S U
MARTIN ARMY COMM HOSPITAL, FT BENNING 31905
CROWDER, JACKSON G. 47 ACT IM
PHYSICIANS BLDG, COLUMBUS 31901
CURL, WALTDN W. 47 ACT ORS
6262 HAMILTON RD, COLUMBUS 31995
DASHIELL, WAVERLEY B. 47 ACT OBG
2039 TENTH AVE, COLUMBUS 31901
DAWSDN, VIRGIL L. 47 I&R
PO BOX 951, COLUMBUS 31994
DEATON, J.H. 47 ACT R
2868 NANCY ST, COLUMBUS 31906
DONAGHY, GEORGE E. 47 R US
127 PALO VERDE DR, LEESBURG FL 32748
DUDLEY, A.B., JR. 47 ACT IM
711 CENTER ST, COLUMBUS 31901
DUPDNT, LOUIS 47 ACT GS
PO BOX 7000, COLUMBUS 31995
DURDEN, JOHN G., JR. 47 ACT GS
1915 SEVENTH AVE, COLUMBUS 31901
EDWARDS, M. DELMAR 47 ACT GS
804 FOURTH AVE, COLUMBUS 31901
ESCDNDO, GERSON Z. 47 ACT P
STE 200 DOCTORS BLDG, COLUMBUS 31901
EVANS, JAMES A. 47 ACT AN
PO BOX 2748, COLUMBUS 31902
EVERIDGE, GEDRGE J. 47 ACT OBG
MEDICAL ARTS BLDG, COLUMBUS 31901
FLANAGAN, WILLIAM C., JR. 47 ACT OBG
500 18TH ST STE B-10, COLUMBUS 31901
FLEMING, CURTIS 47 ACT OBG
STE 102 DOCTORS BLDG, COLUMBUS 31901
FORTSDN, MARK R. 47 ACT IM
1005 TALBOTTON RD, COLUMBUS 31995
FOSTER, THOMAS V. 47 ACT P
1953 SEVENTH AVE, COLUMBUS 31904
FOUNTAIN, ARTHUR J., JR. 47 ACT N
2119 WARM SPRINGS RD, COLUMBUS 31904
FOUNTAIN, LINDA M. 47 ACT PD
2725 EDGEWOOD RD, COLUMBUS 31906
FOX, BRENT 47 ACT OTO
2831 CROMWELL DR, COLUMBUS 31906
FUNK, MARK R. 47 ACT IM
909 CENTER ST, COLUMBUS 31901
GARNETT, ROBERT L. 47 ACT R
PO DRAWER 2787, COLUMBUS 31902
GOLDMAN, KENNETH L. 47 ACT GS
905 CENTER ST, COLUMBUS 31901
GOLDMAN, NORMAN I. 47 ACT IM
909 CENTER ST, COLUMBUS 31901
GOLDSMITH, HDWARD G. 47 ACT ORS
1920 WARM SPRINGS RD, COLUMBUS 31904
GRAHAM, WILLIAM L. 47 ACT R
PO DRAWER 2787, COLUMBUS 31902
GREGORY, JOHN E. 47 ACT PTH
1060 STANDING BOY CT, COLUMBUS 31904
GRIFFIN, E. RAWSON, III 47 DE4 FP
18 WEST WAINWRIGHT, POQUOSON VA 23662
GRIFFIN, JACK T. 47 ACT NS
2009 WARM SPRINGS RD, COLUMBUS 31904
GRIFFITHS, GLENN C. 47 S FP
MARTIN ARMY HOSPITAL, FT BENNING 31905
GRINER, WALLACE 47 ACT EM
5614 ROARING BRANCH RD, COLUMBUS 31904
GURSEL, SEZAI 47 ACT PTH
PO BOX 7000, COLUMBUS 31995
HAGLER, JAMES R., SR. 47 ACT GP
PO BOX 436, BUENA VISTA 31803
HANNA, MAGDI BISHAY 47 ACT FP
5612 WHITESVILLE RD, COLUMBUS 31904
HARPER, WILLIAM M., IV 47 ACT U
1021 TALBOTTON RD, COLUMBUS 31904
HARRIS, J. HENRY WALKER 47 ACT R
2860 CROMWELL DR, COLUMBUS 31906
HAYES, WILLIAM H. 47 ACT FP
2300 MANCHESTER EXPY, COLUMBUS 31904
HENDRIX, MAECDNAS B. 47 ACT ORS
1920 WARM SPRINGS RD, COLUMBUS 31904
HIRSCH, JACK 47 ACT IM
909 CENTER ST, COLUMBUS 31901
HOLLIS, DAN STEPHEN 47 ACT OPH
ST FRANCIS MEDICAL PARK, COLUMBUS 31904
HOOD, JONATHAN C. 47 I&R
PO BOX 951, COLUMBUS 31994
HDRN, EDGAR B. 47 ACT GS
711 CENTER ST STE 224, COLUMBUS 31901
HUBBARD, GEORGE B., JR. 47 ACT OPH
2012 10TH AVE, COLUMBUS 31901
HUBBUCH, SEBASTIAN O. 47 I&R FP
PO BOX 951, COLUMBUS 31994
HUBER, STEPHEN C. 47 ACT DR
6152 CAPE COD CT, COLUMBUS 31904
HUDSDN, RDNALD M. 47 ACT FP
2100 NORTH AVENUE, COLUMBUS 31904
HUDSON, WALTER LLOYD 47 ACT PD
2039 WARM SPRINGS RD, COLUMBUS 31904
HUGHSTON, JACK C. 47 ACT ORS
6262 HAMILTON RD, COLUMBUS 31904
HUNG, LARRY H.Y. 47 ACT PTH
BOX 4176, COLUMBUS 31904
HUNT, JACK R. 47 ACT IM
1005 TALBOTTON RD, COLUMBUS 31995
HUNTER, STEPHEN C. 47 ACT ORS
6262 HAMILTON RD, COLUMBUS 31904
JARRELL, FLOYD C., JR. 47 ACT OTO
PO BOX 4276, COLUMBUS 31995

JARRELL, HAROLD G. 47 ACT OBG
629 20TH ST, COLUMBUS 31904
JENKINS, W.F. 47 ACT R
1580 DIXON DR, COLUMBUS 31906
JOHNSON, C.D. 47 ACT FP
2121 WARM SPRINGS RD, COLUMBUS 31904
JOHNSON, NEAL D. 47 I&R FP
7325 KIRKWOOD DR, COLUMBUS 31904
JONES, FRANK R. 47 I&R
113 SIGERFOOS RD, FT BENNING 31905
KIRTLEY, THOMAS L., JR. 47 S FP
FAMILY PRACTICE CLINID, FT BENNING 31905
KOGANTI, PURNACHANDRA RAO 47 ACT AN
PO BOX 2748, COLUMBUS 31902
KRAVTIN, A.J. 47 ACT PD
1968 NORTH AVE, COLUMBUS 31901
KUDCHADKAR, SOMANATH G. 47 A DR
5051 YOSEMITE DR, COLUMBUS 31907
KUMAR, ASHOK 47 ACT NEP
500 - 18TH ST, COLUMBUS 31901
KURTZ, DONALD M. 47 ACT PTH
PO BOX 4176, COLUMBUS 31904
LABICHE, HENRY 47 ACT PTH
PO BOX 4176, COLUMBUS 31904
LADLEY, D. MARK 47 I&R
6006 OLD DOMINION RD, COLUMBUS 31904
LAKE, MICHAEL H. 47 ACT U
1021 TALBOTTON RD, COLUMBUS 31904
LAPIDES, LEON 47 ACT OTO
DOCTORS BLDG STE 409, COLUMBUS 31901
LAWHORNE, THOMAS W., JR. 47 ACT GS
2522 WARM SPRINGS RD, COLUMBUS 31904
LAWLER, JACK 47 ACT OBG
629 20TH ST, COLUMBUS 31904
LEVY, LOUIS I. 47 ACT PD
1968 NORTH AVE, COLUMBUS 31901
LINTYMER, STEVE 47 ACT PTH
PO BOX 4176, COLUMBUS 31904
LIPSCOMB, GEORGE E. 47 ACT R
PO BOX 2787, COLUMBUS 31902
LODGE, CHARLES G. 47 I&R
PO BOX 2307, MOULTRIE 31768
LOPEZ-LAGD, JOSE A. 47 ACT IM
PO BOX 5307, COLUMBUS 31906
MALONE, THOMAS NATHAN 47 ACT OBG
MEDICAL ARTS BLDG, COLUMBUS 31901
MARCUS, ROBERT D. 47 ACT OTO
2320 HAMILTON RD, COLUMBUS 31904
MAUGHON, BOB R. 47 ACT P
1953 SEVENTH AVE, COLUMBUS 31904
MAYO-ROJAS, HENRY 47 ACT CD,IM
2300 MANCHESTER EXPY, COLUMBUS 31904
MCALLISTER, KATHRYN 47 ACT FP
PO BOX 951, COLUMBUS 31902
MCCANN, SANDRA BRIGGS 47 ACT R
DRAWER 2787, COLUMBUS 31902
MCGEE, THEODORE J. 47 ACT GS
2300 MANCHESTER EXPY, COLUMBUS 31904
MCLEOD, KEVIN 47 I&R
PO BOX 951, COLUMBUS 31994
MCWHIRTER, WILLIAM R. 47 ACT AN
5030 SEARS CT, COLUMBUS 31907
MEINE, FREDERICK J. 47 ACT R
7352 LULLWATER RD, COLUMBUS 31904
MILLER, GORDON C. 47 ACT CD
2300 MANCHESTER EXPY, COLUMBUS 31904
MILLER, JAMES P. 47 ACT
1005 TALBOTTON RD, COLUMBUS 31995
MDLNAR, EDMUND M. 47 ACT GS
101 DOCTORS BLDG, COLUMBUS 31901
MDRAN, MICHAEL P. 47 I&R
PO BOX 951, COLUMBUS 31994
MDRRIS, THOMAS W. 47 ACT FP
PO BOX 749, EATONTON 31024
MUNN, E.K. 47 ACT OBG
1112 JEANETTE AVE, COLUMBUS 31906
MURDOCK, ROBERT N. 47 ACT FP
6309 CAPE COD DR, COLUMBUS 31904
NEWBERRY, DAN C. 47 ACT AN
404 DOCTORS BLDG, COLUMBUS 31901
NEWSOM, BRUCE C. 47 ACT GS
633-19TH ST, COLUMBUS 31901
NORWDOD, LYLE A. 47 ACT ORS
6262 HAMILTON RD, COLUMBUS 31904
ODOM, W.S. 47 ACT GP
422 1/2 NINTH ST, COLUMBUS 31901
OGUZ, SADI 47 ACT P
PO BOX 12435, COLUMBUS 31995
PARIS, RAY BENJAMIN 47 ACT FP
2100 NORTH AVE, COLUMBUS 31904
PATEL, BIPIN 47 ACT IM,PUD
2300 MANCHESTER EXPY, COLUMBUS 31904
PATTERSON, MCLEDD 47 ACT IM
1612 ELMWOOD DR, COLUMBUS 31906
PATTERSON, WILLIAM O., JR 47 ACT P
711 CENTER ST, COLUMBUS 31901
PATTON, ROBERT M. 47 ACT CD
4403 HOLLY AVE, COLUMBUS 31904
PEIKEN, ALAN S. 47 ACT IM
500 - 18TH ST, COLUMBUS 31901
PEIRCE, KENNETH E. 47 ACT A,PDA
MEDICAL ARTS BLDG, COLUMBUS 31901
PETERS, HANS J. 47 ACT PTH
PO BOX 7000, COLUMBUS 31995
PETERSON, DAVID A. 47 ACT IM,NEP
2300 MANCHESTER EXPY, COLUMBUS 31904
PIKE, BENJAMIN F. 47 ACT IM
2300 MANCHESTER EXPY, COLUMBUS 31904
PURDOM, E. STEPHEN 47 ACT IM
1005 TALBOTTON RD, COLUMBUS 31904
PURKS, W. WARREN, JR. 47 ACT IM
ST FRANCIS MEDICAL PARK, COLUMBUS 31904
RAINES, JACK A. 47 ACT P
3228 CODY RD, COLUMBUS 31907
RICE, SAMUEL T. 47 ACT U
1021 TALBOTTON RD, COLUMBUS 31904
RIVERS, JANE 47 A PD
2520 WYNNTON RD, COLUMBUS 31901
RIVERS, W.P., JR. 47 ACT PD
2520 WYNNTON RD, COLUMBUS 31906
ROBBINS, RICHARD S. 47 ACT GE
1905 7TH AVE, COLUMBUS 31901
ROBERTS, DAVID B. 47 ACT OBG
2400 13TH ST, COLUMBUS 31906
ROBERTS, LUTHER J. 47 ACT GS
2300 MANCHESTER RD UNIT F4, COLUMBUS 31904
RODDENBERY, S.A. 47 ACT GS
213 DOCTORS BLDG, COLUMBUS 31901
RODRIGUEZ, ANTONIO R. 47 ACT IM
615-19TH ST, COLUMBUS 31901
ROSS, JACK R. 47 I&R FP
THE MEDICAL CENTER, COLUMBUS 31994
SAMPSON, LLOYD B. 47 ACT D
1408 THIRD AVE, COLUMBUS 31901
SANCHEZ, GEORGE L. 47 I&R
837 EDEN ST, COLUMBUS 31904
SANDERS, RICHARD A. 47 ACT ORS
6262 HAMILTON RD, COLUMBUS 31904
SCHLEY, FRANCIS B., JR. 47 ACT PD
303 11TH ST, COLUMBUS 31901
SCHLEY, MARY W. 47 ACT PD
1527 FOREST AVE, COLUMBUS 31906
SCHLEY, PHILIP T. 47 ACT U
2001 HAMILTON RD, COLUMBUS 31904
SCHUESSLER, GEORGE 47 ACT FP
2854 LYNDA LN, COLUMBUS 31906
SENEVIRATNE, D.G. 47 ACT EM
7158 STANDING BOY RD, COLUMBUS 31904
SERRATD, J.C., JR. 47 ACT ORS
DOCTORS BLDG #320, COLUMBUS 31901
SHANNDN, GEORGE W. 47 ACT FP,IM
PO BOX 951, COLUMBUS 31994
SHEILS, WAYNE C. 47 ACT R
DRAWER 2787, COLUMBUS 31902
SIGMAN, HOLLIS D. 47 ACT AN
404 DOCTORS BLDG, COLUMBUS 31901
SIMMONS, BERNARD RUSSELL 47 ACT U
204 PHYSICIANS BLDG, COLUMBUS 31904
SIMPSON, MARSHALL A. 47 ACT P
2000 - 16TH AVE, COLUMBUS 31901
SIMPSDN, WALTER W. 47 ACT EM
5127 YOSEMITE DR, COLUMBUS 31907
SIMS, MICHAEL COOLIDGE 47 ACT US
2100 NORTH AVE, COLUMBUS 31904
SINCLAIR, CARTER A. 47 ACT FP
PO BOX 951, COLUMBUS 31994
SIZEMORE, JULIAN J., JR. 47 ACT PD
808 21ST ST, COLUMBUS 31904
SKIPWORTH, GEORGE B. 47 ACT D
410 DOCTORS BLDG, COLUMBUS 31901
SMITH, GEORGE BERTLING 47 ACT IM
2300 MANCHESTER EXPY, COLUMBUS 31904
SMITH, HILTON E. 47 ACT FP
2300 MANCHESTER EXPY, COLUMBUS 31904
SMITH, LUTHER J., II 47 ACT P
1953 SEVENTH AVE, COLUMBUS 31904
SORKEY, DAVID 47 ACT CHP
2000 - 16TH AVE, COLUMBUS 31901
SPERK-BARD, EVA 47 ACT PTH
PO BOX 7000, COLUMBUS 31995
STAMEY, CHARLES C. 47 ACT OBG
629-20TH ST, COLUMBUS 31904
STAPLETON, JOHN L. 47 ACT U
2846 COLLEGE DR, COLUMBUS 31901
STAR, FRANKLIN J. 47 ACT GS
905 CENTER ST, COLUMBUS 31901
STEIN, J.D. 47 ACT AN
404 DOCTORS BLDG, COLUMBUS 31901
STEPHENSON, JOHN R. 47 ACT ORS
2009 WARM SPRINGS RD, COLUMBUS 31904
STEWART, DONALD M. 47 ACT AN
404 DOCTORS BLDG, COLUMBUS 31901
STOCKSTILL, J. DEAN 47 I&R
PO BOX 951, COLUMBUS 31994
STOUT, ALAN W. 47 I&R
PO BOX 951, COLUMBUS 31994
SULLIVAN, JAMES H. 47 ACT U
1021 TALBOTTON RD, COLUMBUS 31904
THEUS, THOMAS L. 47 ACT IM
PHYSICIANS BLDG, COLUMBUS 31901
THOMAS, JERRY L. 47 I&R
PO BOX 951, COLUMBUS 31994
THURMAN, LAVON, JR. 47 ACT FP
2121 WARM SPRINGS RD, COLUMBUS 31904
TKALYCH, GEORGE P. 47 ACT OTO,HNS
2039 TENTH AVE, COLUMBUS 31901
TURNER, H.H. 47 ACT IM
ST FRANCIS MEDICAL PARK, COLUMBUS 31904
TYRONE, NELSON O., JR. 47 ACT U
2300 MANCHESTER EXPY BLDG C, COLUMBUS 31904
VAN DUYN, JOHN 47 ACT PS
6345 MOUNTAINVIEW DR, COLUMBUS 31904
VANSANT, JOHNATHAN PAUL 47 ACT IM
2300 MANCHESTER EXPY, COLUMBUS 31904
VARNER, W.D. 47 ACT OBG
2300 MANCHESTER EXPY, COLUMBUS 31904
VAUGHAN, R.H. 47 ACT GS
DOCTORS BLDG #211, COLUMBUS 31901
VENABLE, JAMES H. 47 ACT OBG
PHYSICIANS BLDG STE 104, COLUMBUS 31901
WADE, THOMAS ANDREW, JR. 47 ACT IM
1005 TALBOTTON RD, COLUMBUS 31904
WALDROP, JOHN I. 47 ACT ORS
6262 HAMILTON RD, COLUMBUS 31904
WALKER, PRICE, JR. 47 ACT IM,HEM
PO BOX 9516, COLUMBUS 31908
WALLACE, DDUGLAS W. 47 ACT R
PO BOX 2787, COLUMBUS 31907

WALLACE, ROBERT G. 47 ACT R
PO DRAWER 2787, COLUMBUS 31902
WALLER, ROY M., JR. 47 ACT OBG
PHYSICIANS BLDG, COLUMBUS 31901
WALLNER, HERMAN W. 47 ACT P
2000 16TH AVE, COLUMBUS 31901
WATSON, DAVIS R. 47 ACT OTO
PO BOX 4336, COLUMBUS 31904
WATSON, JOHN D., JR. 47 ACT R
PO DRAWER 2787, COLUMBUS 31902
WAYNE, BARRY A. 47 I&R
PO BOX 951, COLUMBUS 31994
WHITAKER, CECIL F. 47 ACT OBG
629-20TH ST, COLUMBUS 31904
WHITEHURST, JOHN O. 47 ACT PS
PO BOX 7000, COLUMBUS 31995
WILSON, RICHARD H. 47 ACT PS
2200 NORTH AVE, COLUMBUS 31904
WOLFF, LUTHER H. 47 ACT GS
2120 PRESTON DR, COLUMBUS 31906
WOLFF, LUTHER H., JR.MD 47 ACT GS
MEDICAL ARTS BLDG STE 203, COLUMBUS 31901
WOLFF, WILLIAM A. 47 ACT GS
MEDICAL ARTS BLDG, COLUMBUS 31901
WOOD, RICHARD ELGIN, JR. 47 ACT FP
2300 MANCHESTER EXPY, COLUMBUS 31904
WORMAN, ROBERT K. 47 ACT GS
PO BOX 951, COLUMBUS 31902
YARBROUGH, JAMES E. 47 ACT OTO
1909 IRIS DR, COLUMBUS 31906
YARBROUGH, SIDNEY H., III 47 ACT ORS
2300 MANCHESTER EXPY, COLUMBUS 31904
YOE, LIONEL MEREDITH 47 ACT OPH
DOCTORS BLDG #109, COLUMBUS 31901
ZUBOWICZ, GEORGE 47 ACT P
2000 - 16TH AVE, COLUMBUS 31901

48—NEWTON-ROCKDALE

ABBOTT, EMILE G. 48 ACT IM
PO BOX 571, CONYERS 30207
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BERSON, MICHAEL J. 48 ACT U
4140 TATE ST, COVINGTON 30209
BOYLE, STEPHEN 48 ACT GS
1359 MILSTEAD RD STE 202, CONYERS 30207
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2537 HIGHLAND DR, CONYERS 30207
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DHARAMSI, MOHAMED N. 48 ACT OBG
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1309 MILSTEAD RD, CONYERS 30207
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4555 NORTH SHALLOWFORD RD, DUNWOODY 30338
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PARK, GEORGE T. 48 ACT IM
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1315 MILSTEAD RD, CONYERS 30207
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PIEDRAHITA, PABLO 48 ACT GS
2111 FLAT SHOALS RD, CONYERS 30208
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1359 MILSTEAD RD #202, CONYERS 30207
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5126 HOSPITAL DR, COVINGTON 30209
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5303 ADAMS ST NE, COVINGTON 30209
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2111 FLAT SHOALS RD STE 105, CONYERS 30208
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3848 TAWNY BIRCH CT, DECATUR 30034
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258 GAITHER RD, MANSFIELD 30255

49—OCONEE VALLEY

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PO DRAWER 760, EATONTON 31024
FERRELL, M. LYNN 49 ACT FP
325 EAST BROAD ST, SPARTA 31087
GARCIA, SAMUEL I. 49 ACT OBG
PO BOX 16, MADISON 30650
GIBSON, WALLACE M. 49 ACT GS
106 NORTH JEFFERSON ST, EATONTON 31024
GREEN, GEORGE F. 49 ACT FP
525 SPRING ST, SPARTA 31087
KUMAR, RAKESH 49 ACT GS
PO DRAWER 551, EATONTON 31024
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PARKER, J. LEE 49 ACT FP
PO BOX 179, GREENSBORO 30642
RHODES, WILLIAM H., JR. 49 ACT FP
100 SCOTT ST, UNION POINT 30669
THORNTON, H.A. 49 ACT FP
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WEAVER, ROSE ANN RIGBY 49 ACT IM
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BATTS, A.S. 50 ACT GP
116 LUMPKIN ST, HAWKINSVILLE 31036
BIVINS, BLAKE S. 50 ACT FP
404 BEECH ST, COCHRAN 31014
BRIGGS, WILLIAM J., III 50 ACT FP
PO BOX 97, MILAN 31060
BROOKS, CHARLES P. 50 ACT FP
PO BOX 35, COCHRAN 31014
BUTLER, JACK A. 50 ACT FP
PO BOX 666, UNADILLA 31091
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PO BOX 469, HAWKINSVILLE 31036
GATTIS, LARRY D. 50 ACT FP
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GEORGI, EMIL B. 50 ACT PTH
PO BOX 956, EASTMAN 31023
JUN, CHANNING S. 50 ACT GS
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LEE, KUO LAM 50 ACT R
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LEWIS, MYRON KEITH 50 ACT IM
PULASKI PROFESS BLDG, HAWKINSVILLE 31036
LONG, HAROLD W. 50 ACT FP
PO BOX 400, EASTMAN 31023
PATTERSON, GEORGE W. 50 ACT FP
717 GRIFFIN ST, EASTMAN 31023
SMITH, R.L. 50 ACT FP
455 PEACOCK ST, COCHRAN 31014
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104 EAST DYKES ST, COCHRAN 31014
TISON, JAMES H. 50 ACT IM
717 GRIFFIN ST, EASTMAN 31023
WALKER, GEORGE S., III 50 ACT IM
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WILLIAMS, OTIS J., JR. 50 ACT OBG
PO BOX 848, EASTMAN 31023

53—RANDOLPH-STEWART-TERRELL

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PO BOX 482, DAWSON 31742
BATES, JOHN G. 53 ACT FP
201 RANDOLPH ST, CUTHBERT 31740
DELGADO, EMILIO 53 ACT GS
303 JOHNSON ST, DAWSON 31742
KAVELMAN, DOUGLAS A. 53 ACT IM
PO BOX 687, LUMPKIN 31815
MARTIN, ROBERT B., III 53 R GS
201 RANDOLPH ST, CUTHBERT 31740
MARTIN, WALTER D. 53 R FP
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WARD, CHARLES M. 53 ACT FP
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WATTANAWANAKUL, SOMSAK 53 ACT R,GP
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AGOSTAS, W.N. 54 ACT IM
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AKTUNC, DOGAN R. 54 ACT IM
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ALLEN, MARSHALL B., JR. 54 ACT N
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ALLSBROOK, WILLIAM C. 54 ACT PTH
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ALPERIN, HENRY 54 ACT R
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ALTHISAR, H.M., SR. 54 ACT FP
4 EAGLETON CT, AUGUSTA 30909
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ASSAD, RAMZI T. 54 ACT IM
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1350 WALTON WAY (10), AUGUSTA 30910
BAILEY, HENRY WRIGHT 54 ACT GS
1443 ANTHONY RD, AUGUSTA 30904
BAILEY, JOSEPH P. 54 ACT IM
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BAILEY, T.E. 54 ACT PD
1111 DRUID PARK AVE, AUGUSTA 30904
BAILEY, THOMAS E., JR. 54 ACT ORS
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BALL, HENRY FAVER 54 ACT P
2350 WASHINGTON RD, AUGUSTA 30904
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820 ST SEBASTIAN WAY STE 6C, AUGUSTA 30902
BARFIELD, WILLIAM E., SR. 54 ACT OBG
1510 JOHNS RD, AUGUSTA 30904
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3623 J DEWEY GRAY CIR #107, AUGUSTA 30909
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3940 WASHINGTON RD, MARTINEZ 30907
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1417 PENDLETON RD, AUGUSTA 30904
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3023 PINE NEEDLE RD, AUGUSTA 30909
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BELK, BEVERLY 54 I&R PD
3370 TANGLEWOOD DR, AUGUSTA 30909
BELL, J.E. 54 ACT PD
2211 CRESTWOOD DR, AUGUSTA 30904
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BLANCHARD, THOMAS W. 54 ACT U
1512 ANTHONY RD, AUGUSTA 30904
BLITCH, PIERCE G., JR. 54 ACT IM
820 ST SEBASTIAN WAY STE 3-A, AUGUSTA 30902
BLIVEN, FLOYD E., JR. 54 ACT ORS
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BLOUNT, WADE B. 54 ACT OBG
820 ST SEBASTIAN WAY, AUGUSTA 30904
BOHLER, CLORINDA S. 54 ACT EM
2279 WRIGHTSBORO RD, AUGUSTA 30904
BOWDEN, TALMADGE A., JR. 54 ACT GS
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BOWEN, JOHN L. 54 DE2 PD
PO BOX 15226, ASHEVILLE NC 28803
BOYD, CLAUD A., JR. 54 ACT D
1509 ANTHONY RD, AUGUSTA 30904
BOYD, WILLIAM S. 54 ACT OBG
1501 WINTER ST, AUGUSTA 30904
BRAND, ROBERT L. 54 ACT ORS
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BRIDGES, H. BENTON 54 ACT ORS
1138 DRUID PARK AVE, AUGUSTA 30904
BRIDGES, MERCER T. 54 ACT ORS
3623 J DEWEY GRAY CIR #103, AUGUSTA 30909
BROOKS, BETTY SUE 54 ACT DR
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3636 WHEELER RD, AUGUSTA 30909
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820 ST SEBASTIAN WAY, AUGUSTA 30902
BROWN, STEPHEN W. 54 ACT R
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BRUNS, WILLIAM L., JR. 54 ACT OBG
1430 HARPER ST, AUGUSTA 30910
BRYANS, C.I., JR. 54 ACT OBG
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820 ST SEBASTIAN WAY STE 1-A, AUGUSTA 30901
BURDISON, WILLIAM R. 54 S IM
2410 WILLIAMS ST, AUGUSTA 30904
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3614 J DEWEY GRAY CIR STE D, AUGUSTA 30909
BURGESS, RUSSELL E. 54 ACT ON
2101 CENTRAL AVE, AUGUSTA 30904
BUSH, LEON H. 54 ACT IM
1507 ANTHONY RD, AUGUSTA 30904
BYARS, WILLIAM P., JR. 54 ACT OBG
3614 J DEWEY GRAY CIR STE D, AUGUSTA 30909
BYTELL, DAVID E. 54 ACT ORS
1511 ANTHONY RD, AUGUSTA 30904
CALDWELL, JOSEPH L., JR. 54 ACT GS
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3623 J DEWEY GRAY CIR ' 201, AUGUSTA 30909
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CARTER, JACK W., JR. 54 ST
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4212 DUNWOODY RD, MARTINEZ 30907
CLARK, SARAH L. 54 ACT IM
3623 J DEWEY GRAY CIR ' 308, AUGUSTA 30909
CLARK, WILLIAM L., JR. 54 ACT ORS
820 ST SEBASTIAN WAY STE 8, AUGUSTA 30902
CLARY, THOMAS L., JR. 54 R IM
712 OBERLIN RD, AUGUSTA 30909
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820 ST SEBASTIAN STE 3-D, AUGUSTA 30902
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1109 MEDICAL CENTER DR, AUGUSTA 30909
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1450 ANTHONY RD, AUGUSTA 30904
COLLINS, MYRON D.F. 54 ACT ORS
PO BOX 2806, AUGUSTA 30904
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COOK, JOHN R. 54 ACT D
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COOK, TERRENCE J. 54 ACT IM
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3623 J DEWEY GRAY CIR ' 310, AUGUSTA 30909
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820 SEBASTIAN WAY 4-C, AUGUSTA 30910
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EWING, DOUGLAS E. 54 ACT P
2350 WASHINGTON RD, AUGUSTA 30904
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FADEL, SKINA H. 54 ACT AN
3503 LOST TREE CT, AUGUSTA 30907
FALLS, DORTH G. 54 I&R PTH
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1120 15TH ST, AUGUSTA 30912
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1021 - 15TH ST STE 12, AUGUSTA 30901
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3623 J DEWEY GRAY CIR ' 313, AUGUSTA 30909
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FINNEY, H. RAY 54 ACT U
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FIVEASH, ARLIE E. 54 ACT R
820 ST SEBASTIAN STE 1-A, AUGUSTA 30902
FLANAGIN, W. STEWART 54 ACT PS
1125 DRUID PARK AVE, AUGUSTA 30904
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820 ST SEBASTIAN WAY STE 2D, AUGUSTA 30902
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903-15TH ST, AUGUSTA 30901
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3623 J DEWEY GRAY CIR ' 205, AUGUSTA 30909
GARRISON, GLEN E. 54 ACT CD
3211 DRESDEN WAY, AUGUSTA 30909
GARRISON, JOSEPH M. 54 ACT AN
812 13TH ST, AUGUSTA 30901
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1303 BIMINI PL, AUGUSTA 30909
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3614 J DEWEY GRAY CIR STE D, AUGUSTA 30909
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1521 ANTHONY RD, AUGUSTA 30904
GRAHAM, HAMLIN 54 ACT ORS
1021 15TH ST STE 8, AUGUSTA 30901
GRAMLING, Z.W. 54 ACT AN
TALMADGE MEMORIAL HOSPITAL, AUGUSTA 30902
GRAY, J.D. 54 ACT IM
3623 J DEWEY GRAY CIR ' 209, AUGUSTA 30909
GRAY, O.L., JR. 54 ACT FP
1224 WEST MARKS CHURCH RD, AUGUSTA 30909
GREEN, MARGARET GRAHAM ORR 54 ACT OPH
1514 ANTHONY RD, AUGUSTA 30904
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903 - 15TH ST, AUGUSTA 30902
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GUILL, MARGARET F. 54 ACT AL
2247 PICKENS RD, AUGUSTA 30904
GULLEN, WARREN H. 54 ACT ID
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HAAS, MELVYN L. 54 ACT N
820 ST SEBASTIAN WAY STE 5-C, AUGUSTA 30902
HAGLER, MARY ANNE TYLER 54 ACT FP
999 HIGHLAND AVE, AUGUSTA 30904
HANSON, THOMAS A. 54 ACT PD
3623 J DEWEY GRAY CIR ' 203, AUGUSTA 30909
HARMON, JOHN O. 54 ACT GS,OTO
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HARPER, HARRY T., JR. 54 ACT IM
820 ST SEBASTIAN WAY STE 2-A, AUGUSTA 30902
HARPER, HERBERT S. 54 ACT PD
1430 HARPER ST BLDG C STE 2, AUGUSTA 30910
HARRISON, F.N. 54 ACT OBG
1021 15TH ST, AUGUSTA 30901
HARTLAGE, PATRICIA L. 54 ACT OS
MEDICAL COLLEGE OF GEORGIA, AUGUSTA 30902
HASTINGS, E.V. 54 ACT PTH
2260 WRIGHTSBORO RD, AUGUSTA 30910
HEALEY, KENNETH W. 54 I&R OBG
1706 KINGS WOOD DR, AUGUSTA 30904
HENSLEY, E.A. 54 R GP
1259 PINE LOG RD, CONYERS 30207
HENSLEY, E.R. 54 ACT EM
2431 PEACH ORCHARD RD, AUGUSTA 30906
HILL, ROBERT S. 54 ACT GS
1503 WINTER ST, AUGUSTA 30904
HOBBS, JOSEPH 54 ACT FP
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HOBSON, OOUGLAS P. 54 ACT P
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HOGUE, WILLIAM L. 54 ACT R
820 ST SEBASTIAN WAY, AUGUSTA 30902
HOLZMAN, GERALD B. 54 ACT OBG
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HOOKS, VENOIE H., III 54 ACT CRS
MEDICAL COLLEGE OF GEORGIA, AUGUSTA 30912
HORSEMAN, ROBERT W. 54 ACT AN
PO BOX 261, EVANS 30809
HOUSE, FREORICK C. 54 ACT AL,IM
3646 WHEELER RD STE 1-A, AUGUSTA 30909
HOWARO, T.J. 54 ACT IM,GER
2316 WRIGHTSBORO RD, AUGUSTA 30904
HOWELL, CHARLES G., JR. 54 ACT PDS
1120 15TH ST, AUGUSTA 30912
HOWINGTON, JERRY W. 54 ACT R
820 ST SEBASTIAN WAY, AUGUSTA 30902
HUDSON, JACK 54 ACT FP
BOX 5787, AUGUSTA 30906
HUDSON, JAMES B. 54 ACT IM
TALMADGE MEMORIAL HOSPITAL, AUGUSTA 30912
HUDSON, WILLIAM H. 54 ACT ORS
820 ST SEBASTIAN WAY, AUGUSTA 30910
HUFF, THOMAS A. 54 ACT END
MEDICAL COLLEGE OF GEORGIA, AUGUSTA 30912
HUGHES, JOHN L. 54 ACT P
2058 CENTRAL AVE, AUGUSTA 30904
HULL, DAVIO S. 54 ACT OPH
MEDICAL COLLEGE OF GEORGIA, AUGUSTA 30912
HUMPHRIES, ARTHUR L., JR. 54 ACT GS
TALMADGE MEMORIAL HOSPITAL, AUGUSTA 30912
IHNEN, MENARD 54 ACT PTH
1350 WALTON WAY (10), AUGUSTA 30910
JAY, M. SUSAN 54 ACT PD
MEDICAL COLLEGE OF GEORGIA, AUGUSTA 30910
JAY, WALTER M. 54 ACT OPH
MEDICAL COLLEGE OF GEORGIA, AUGUSTA 30912
JEANS, PARK C., JR. 54 ACT OPH
1021-15TH ST STE 5, AUGUSTA 30901
JENNINGS, W.D., JR. 54 ACT GS
VA HOSPITAL, AUGUSTA 30904
JOHN, FARES 54 ACT PTH
MEDICAL COLLEGE OF GEORGIA, AUGUSTA 30904
JOHNSON, C.F., JR. 54 ACT AN
8 WHITE OAK DR, NORTH AUGUSTA SC 29841
JOHNSON, JANET K. 54 ACT PD,EM
1350 WALTON WAY, AUGUSTA 30904
JOHNSON, JIMPSEY B. 54 ACT R
820 ST SEBASTIAN WAY STE 1-A, AUGUSTA 30902
JOHNSON, JULIUS T. 54 ACT P
820 ST SEBASTIAN WAY STE 3-B, AUGUSTA 30902
JOHNSON, RAY E. 54 ACT CD
820 ST SEBASTIAN WAY, AUGUSTA 30902
JOHNSON, ROBERT H., JR. 54 ACT GS
MEDICAL COLLEGE OF GEORGIA, AUGUSTA 30912
JOHNSON, ROBERT W. 54 ACT GS
820 ST SEBASTIAN WAY STE 7-C, AUGUSTA 30902
JOHNSON, WALTER E., JR. 54 ACT AN
BOX 3403 HILL STATION, AUGUSTA 30904
JOHNSTON, JOSEPH F. 54 ACT AN
MEDICAL COLLEGE OF GEORGIA, AUGUSTA 30912
JONES, G. FRANK, JR. 54 ACT GS
1503 WINTER ST, AUGUSTA 30904
JONES, KENNETH O. 54 ACT P
2058 CENTRAL AVE, AUGUSTA 30904
JOWERS, J.R. 54 ACT FP
210 OAK ST, MARTINEZ 30907
KANTO, WILLIAM P., JR. 54 ACT PD
MEDICAL COLLEGE OF GEORGIA, AUGUSTA 30912
KATZ, DAVID S. 54 ACT GP,OM
3109 NATALIE CIR, AUGUSTA 30909
KAUFMAN, NATHAN 54 ACT OS
1003 CHAFEE AVENUE, AUGUSTA 30904
KAY, JAMES B., JR. 54 ACT U
1021 15TH ST, AUGUSTA 30901
KELLEY, JOHN WALTER 54 ACT CDS
820 ST SEBASTIAN WAY STE 6-A, AUGUSTA 30902
KELLY, ROBERT O. 54 ST
MEDICAL COLLEGE OF GEORGIA, AUGUSTA 30912
KERINS, CRAIG T. 54 ACT ORS
1521 ANTHONY RD, AUGUSTA 30910
KILPATRICK, ZACHARY M. 54 ACT GE
820 ST SEBASTIAN WAY STE 2-C, AUGUSTA 30902
KITCHENS, WILLIAM R. 54 ACT TS,CDS
820 ST SEBASTIAN WAY, AUGUSTA 30904
KLEMANN, GILBERT L. 54 ACT IM
1021-15TH ST #3, AUGUSTA 30901
KRAUSS, JONATHAN SETH 54 ACT PTH
MEDICAL COLLEGE OF GEORGIA, AUGUSTA 30901
KRAWIECKI, NICOLAS S. 54 ACT PD
MEDICAL COLLEGE OF GA CK286, AUGUSTA 30912
KUGLAR, HELEN B. 54 ACT OBG
1511 JOHNS RD, AUGUSTA 30904
KUSKE, TERRENCE T. 54 ACT IM
MEDICAL COLLEGE OF GEORGIA, AUGUSTA 30912
LABINER, DAVID M. 54 ST
MEDICAL COLLEGE OF GEORGIA, AUGUSTA 30912
LAMMERS, JOHN E. 54 I&R IM
1439 TROUPE ST, AUGUSTA 30904
LAMOTTE, IRENE F. 54 R DR
820 ST SEBASTIAN STE 1-A, AUGUSTA 30902
LAVIGNE, WILLIAM E. 54 ACT OBG
2042 CENTRAL AVE, AUGUSTA 30904
LAWRENCE, WILLIAM POWELL 54 ACT TR
820 ST SEBASTIAN WAY, AUGUSTA 30902
LEE, JOSEPH O. 54 ACT GS
3032 LAKE FOREST DR, AUGUSTA 30909
LEMON, RODMAN, JR. 54 ACT OBG
3614 J DEWEY GRAY CIR STE D, AUGUSTA 30909

LENNOX, KENNETH W. 54 ACT U
VA MEDICAL CENTER, AUGUSTA 30910
LEONARO, ROBERT 54 ACT OTO
1109 TELFAIR ST, AUGUSTA 30901
LEVY, JACK H. 54 ACT R
1450 WINTER ST, AUGUSTA 30902
LINOER, CHARLES W. 54 ACT PD
MEDICAL COLLEGE OF GEORGIA, AUGUSTA 30912
LITTLE, ROBERT C. 54 ACT CD
MEDICAL COLLEGE OF GEORGIA, AUGUSTA 30912
LOFTIS, WILLIAM EOWIN 54 ACT R
1427 HARPER ST, AUGUSTA 30909
LONG, EUGENE M., JR. 54 ACT OBG
1810 CENTRAL AVE, AUGUSTA 30904
LOOMIS, EARL A., JR. 54 ACT P,CHP
1515 POPE AVE, AUGUSTA 30912
LOTT, THOMAS M. 54 ACT R
PO BOX 10106, AUGUSTA 30903
LUCAS, WILLIAM T. 54 ACT U
1276 MERRY ST, AUGUSTA 30904
LUXENBERG, MALCOLM N. 54 ACT ORS
1120 15TH ST, AUGUSTA 30912
MAGRUDER, RICHARO L., JR. 54 ACT IM
820 ST SEBASTIAN STE 5-A, AUGUSTA 30902
MAHONEY, PAUL O. 54 ACT AN
3208 MONTPELIER DR, AUGUSTA 30909
MALONEY, G. RUFUS 54 I&R U
3522 IRONWOOD DR, AUGUSTA 30907
MANOAL, ANIL K. 54 ACT IM,NEP
VA MEDICAL CENTER 111F, AUGUSTA 30910
MANGANIELLO, LOUIS O.J. 54 ACT NS
820 ST SEBASTIAN WAY STE 6-B, AUGUSTA 30902
MANSBERGER, ARLIE 54 ACT GE
MEDICAL COLLEGE OF GEORGIA, AUGUSTA 30912
MARKHAM, JOHN C., III 54 ACT GE
1514 ANTHONY RD, AUGUSTA 30904
MARSCHALK, F.F., JR. 54 ACT IM
1500 JOHNS RD, AUGUSTA 30904
MARSHALL, LOUIE W. 54 ACT P
2301 WRIGHTSBORO RD, AUGUSTA 30904
MARTIN, JOHN M. 54 ACT IM
1258 MERRY ST, AUGUSTA 30904
MASSENGALE, L.R. 54 ACT PD
1903 ROCK SPRINGS DR, AUGUSTA 30904
MASSEY, CLINTON E. 54 I&R NS
MEDICAL COLLEGE OF GEORGIA, AUGUSTA 30912
MATTAS, ANNE T. 54 ACT IM
MEDICAL COLLEGE OF GEORGIA, AUGUSTA 30904
MAXEY, JOY A. 54 I&R
605 LENOX WAY, ATLANTA 30324
MCCLURE, CHARLES G. 54 ACT N
1029 CHAFEE AVE, AUGUSTA 30904
MCCORO, JAMES W. 54 ACT N
1514 ANTHONY RD, AUGUSTA 30904
MCCRANIE, MARTHA S. 54 ACT P
742 LANCASTER RD, AUGUSTA 30909
MCOONALD, J. KENNETH 54 ACT P
3623 J DEWEY GRAY CIR ' 206, AUGUSTA 30909
MCOONOUGH, PAUL G. 54 ACT OBG
TALMADGE MEMORIAL HOSPITAL, AUGUSTA 30912
MCGAHEE, ROBERT C. 54 ACT PD
2817 HILLCREST AVE, AUGUSTA 30909
MCGARITY, SEABORN S., JR. 54 ACT P
820 ST SEBASTIAN WAY STE 3-D, AUGUSTA 30902
MCKENNEY, JOEL RAY 54 ACT P
1500 JOHNS RD, AUGUSTA 30904
MCKNIGHT, ROBERT R. 54 R ORS
1134 DRUID PARK AVE, AUGUSTA 30904
MCLAIN, E.K. 54 ACT IM
748 LANCASTER RD STE A, AUGUSTA 30909
MCLEOD, NATLIE BOWEN 54 I&R NTR
422 ASHLAND DR, AUGUSTA 30909
MCLEOD, WALLACE N., JR. 54 ACT OPH
3640 WHEELER RD, AUGUSTA 30909
MCMICHAEL, ALICE O. 54 ACT P
3643 WALTON WAY EXT, AUGUSTA 30909
MCNAIR, HAL 54 ACT FP
3623 J DEWEY GRAY CR, AUGUSTA 30909
MCRAE, DONALD R., JR. 54 ACT GS
1256 MERRY ST, AUGUSTA 30904
MEEKS, WILLIAM H. 54 ACT NS
820 ST SEBASTIAN WAY, AUGUSTA 30910
MILLER, ABRAHAM 54 ACT OBG
1270 MERRY ST, AUGUSTA 30904
MIXON, GEORGE E. 54 ACT FP
640 CARLTON DR, AUGUSTA 30909
MOLINARO, JOHN R. 54 ACT GE
820 ST SEBASTIAN WAY STE 7-B, AUGUSTA 30902
MONGAN, PATRICK F. 54 ACT FP
MEDICAL COLLEGE OF GEORGIA, AUGUSTA 30912
MOORE, VICTOR A. 54 ACT IM
UNIVERSITY HOSP, AUGUSTA 30902
MOORES, RUSSELL R. 54 ACT IM
MEDICAL COLLEGE OF GEORGIA, AUGUSTA 30912
MORETZ, WILLIAM H. 54 ACT GS
TALMADGE MEMORIAL HOSPITAL, AUGUSTA 30912
MORGAN, MARY E. 54 ACT IM
VA HOSPITAL, AUGUSTA 30910
MOSS, BENJAMIN F., JR. 54 ACT P
820 ST SEBASTIAN WAY STE 3-D, AUGUSTA 30902
MOSS, RICHARD N. 54 ACT FP
1417 PENDLETON RD, AUGUSTA 30904
MOTE, PAUL S. 54 ACT AN
MEDICAL COLLEGE OF GEORGIA, AUGUSTA 30912
MOUNA, YOUSSEF 54 ACT IM
1109 MEDICAL CENTER DR, AUGUSTA 30909
MULHERIN, C.S. 54 ACT GS
1527 GWINNETT ST, AUGUSTA 30904
MULHERIN, JOSEPH L. 54 ACT GS
820 ST SEBASTIAN WAY STE 4-D, AUGUSTA 30901
MULLINS, WILLIAM B. 54 ACT PTH
1402 WALTON WAY, AUGUSTA 30904
MURPHEY, ALEX T. 54 ACT IM
820 ST SEBASTIAN WAY STE 7-A, AUGUSTA 30902
MURPHY, MICHAEL J. 54 ACT OPH
1514 ANTHONY RD, AUGUSTA 30904
NATRAJAN, PUTHUGRAMAM K. 54 ACT OBG,END
903 - 15TH ST, AUGUSTA 30901
NEAL, RUTH E. 54 ACT R
1926 BYRNES RD, NORTH AUGUSTA SC 29841
NECHTMAN, CARL M. 54 ACT OTO
1511 ANTHONY RD, AUGUSTA 30904
NELSON, ELLIS H. 54 ACT R
PO BOX 10106, AUGUSTA 30903
NELSON, GEORGE H. 54 ACT OBG
MEDICAL COLLEGE OF GEORGIA, AUGUSTA 30912
NELSON, MAYNARD 54 ACT GS
1502 ANTHONY RD, AUGUSTA 30904
NESBITT, ROBERT R., JR. 54 ACT GS
MEDICAL COLLEGE OF GEORGIA, AUGUSTA 30912
NICHOLS, POMEROY 54 ACT NS
820 ST SEBASTIAN WAY, AUGUSTA 30910
O'QUINN, JAMES L. 54 ACT PTH
PO BOX 2406, AUGUSTA 30903
O'QUINN, MARY H. 54 ACT PTH
3651 WHEELER RD, AUGUSTA 30910
O'REAR, HARRY B. 54 ACT PD
MEDICAL COLLEGE OF GEORGIA, AUGUSTA 30912
OLDHAM, HARRY M., JR. 54 ACT OBG
2300 WRIGHTSBORO RD, AUGUSTA 30904
OLIVER, JOHN H. 54 ACT OBG
1501 ANTHONY RD, AUGUSTA 30910
OLLER, JOSEPH L. 54 ACT AN
812-13TH ST, AUGUSTA 30901
OROSZ, JUDY I. 54 ACT PD
1350 WALTON WAY, AUGUSTA 30910
OTKEN, LUTHER B., JR. 54 ACT PTH
TALMADGE MEMORIAL HOSPITAL, AUGUSTA 30902
OWEN, RALPH G. 54 ACT OBG
1710 CENTRAL AVE, AUGUSTA 30904
PAKALNIS, VYTAUTAS A. 54 ACT OPH
MEDICAL COLLEGE OF GEORGIA, AUGUSTA 30912
PARRISH, ROBERT A., JR. 54 ACT GS
TALMADGE MEMORIAL HOSPITAL, AUGUSTA 30912
PATTISON, E. MANSELL 54 ACT P
MEDICAL COLLEGE OF GEORGIA, AUGUSTA 30912
PATTON, MAURICE G. 54 ACT PH
822 WINDSOR CT, AUGUSTA 30909
PAYNE, F. EOWARO, JR. 54 ACT FP
MEDICAL COLLEGE OF GEORGIA, AUGUSTA 30912
PAYNE, R.F. 54 ACT PH
3404 WALTON WAY EXT, AUGUSTA 30902
PENNINGTON, WEEMS RUFUS, JR. 54 ACT IM
820 ST SEBASTIAN WAY STE 2-A, AUGUSTA 30902
PERKINS, H.R. 54 ACT OTO
4901 VAN CISE RD, ALBANY 31707
PERSALL, JOHN T. 54 ACT OBG
PO BOX 3584, AUGUSTA 30904
PESKIN, HERMAN 54 ACT IM
820 ST SEBASTIAN WAY STE 7-A, AUGUSTA 30902
PETWAY, JAMES M. 54 I&R IM
28 CAMELLIA CIR, NEWNAN 30263
PHILLIPS, CAROL ANN 54 ACT P
VA MEDICAL CENTER, AUGUSTA 30910
PINSON, HARRY O. 54 ACT GS
ONE BRANSFORD PL, AUGUSTA 30904
POOL, WINFORO H., JR. 54 ACT R
TALMADGE MEMORIAL HOSPITAL, AUGUSTA 30912
PORUBSKY, EOWARD S. 54 ACT OTO
MEDICAL COLLEGE OF GEORGIA, AUGUSTA 30912
POWELL, BARBARA A. 54 ACT OBG
1505 ANTHONY RD, AUGUSTA 30904
PRATHER, STUART H., JR. 54 ACT R
3623 J DEWEY GRAY CR, AUGUSTA 30909
PRISANT, LOUIS M. 54 ACT IM,CD
MEDICAL COLLEGE OF GEORGIA, AUGUSTA 30912
PRUITT, ALBERT W. 54 ACT PD
MEDICAL COLLEGE OF GEORGIA, AUGUSTA 30912
PRYOR, CAROL G. 54 ACT OBG
1500 JOHNS RD, AUGUSTA 30904
PURSLEY, NORMAN B. 54 ACT OS
GEORGIA TRAINING SCHOOL, GRACEWOOD 30812
QUANTZ, NEWTON G., JR. 54 ACT OTO
2283 WRIGHTSBORO RD, AUGUSTA 30904
QUILLIAN, WILLARO E., III 54 ACT P
MEDICAL COLLEGE OF GEORGIA, AUGUSTA 30912
RAO, R.N. 54 ACT PTH
MEDICAL COLLEGE OF GEORGIA, AUGUSTA 30912
REEVES, NATHAN 54 ACT IM
2264 WRIGHTSBORO RD, AUGUSTA 30904
REIMER, JONATHAN EOWARO 54 ACT FP
1224 WEST MARKS CHURCH RD, AUGUSTA 30909
REYNOLOS, JOHN O., III 54 ACT NS
820 ST SEBASTIAN WAY, AUGUSTA 30910
RHOOE, C. MARTIN 54 R GS
2347 REDWOOD DR, AUGUSTA 30904
RICHAROSON, OEBORAH K. 54 ACT PTH
1402 WALTON WAY, AUGUSTA 30901
RINKER, J. ROBERT 54 ACT U
MEDICAL COLLEGE OF GEORGIA, AUGUSTA 30902
RISSING, JOHN PETER 54 ACT IM
VA HOSPITAL DD, AUGUSTA 30910
ROBINSON, HENRY A., JR. 54 ACT OBG
3001 GORDON HWY HWY 78, GROVETOWN 30813
RODRIGUEZ-TORRES, JOSE O. 54 I&R PD
1660 MULKEY RD STE C, AUSTELL 30001
ROULE, J. VICTOR 54 ACT OTO
2251 CUMMING RD, AUGUSTA 30904
RUBIN, JOSEPH W. 54 ACT TS
MEDICAL COLLEGE OF GEORGIA, AUGUSTA 30912
RUCKER, J.T., JR. 54 ACT AN
812 13TH ST, AUGUSTA 30901
RYCHLY, ROBERT E. 54 ACT IM
820 ST SEBASTIAN WAY STE 7-A, AUGUSTA 30901
SANOERS, CONRAO W., JR. 54 ACT GS
1430 HARPER ST, AUGUSTA 30902
SANDERS, RUTH T. 54 ACT R
PO BOX 3658, AUGUSTA 30904

SAUNDERS, ELWYN A. 54 ACT ORS
MEDICAL COLLEGE OF GEORGIA, AUGUSTA 30912
SAVAGE, JOHN B. 54 ACT ORS
3623 J DEWEY GRAY CIR, MARTINEZ 30909
SCHILLING, ROBINSON W., JR. 54 ACT OTO
2283 WRIGHTSBORO RD, AUGUSTA 30904
SCHUMAN, BERNARD M. 54 ACT IM,GE
MEDICAL COLLEGE OF GEORGIA, AUGUSTA 30912
SCOGGINS, BRENDA B. 54 ACT P
136 LAKEWOOD PL BOX 55, GRACEWOOD 30812
SCOGGINS, HENRY D. 54 ACT OBG
1500 JOHNS RD, AUGUSTA 30904
SEHGAL, NARINDER N. 54 ACT OBG
1350 WALTON WAY, AUGUSTA 30901
SELL, M.B., JR. 54 ACT P
MEDICAL COLLEGE OF GEORGIA, AUGUSTA 30912
SERVY, EDOUARD JEAN 54 ACT OBG
812 CHAFEE AVE, AUGUSTA 30904
SHAH, KAMLA J. 54 ACT TR
MEDICAL COLLEGE OF GEORGIA, AUGUSTA 30912
SHEPHERD, MASON H. 54 ACT GS
1430 HARPER ST, AUGUSTA 30902
SHERLINE, DONALD 54 ACT OBG
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SHERMAN, HARRY C. 54 ACT GS
1430 HARPER ST, AUGUSTA 30902
SHIVER, CHARLES B. 54 ACT IM
806-13TH ST, AUGUSTA 30901
SHLAER, STEPHEN M. 54 ACT ON
820 ST SEBASTIAN WAY, AUGUSTA 30910
SINGH, MANJIT 54 ACT GE
VA HOSPITAL MEDICAL CENTER, AUGUSTA 30910
SINGLETARY, ELIZABETH A. 54 ACT IM
MEDICAL COLLEGE OF GEORGIA, AUGUSTA 30912
SKLAR, ALLAN H. 54 ACT IM,NEP
MEDICAL COLLEGE OF GEORGIA, AUGUSTA 30912
SMITH, AMOS A. 54 ACT AN
PO BOX 2765, AUGUSTA 30904
SMITH, ARTHUR M. 54 ACT U
MEDICAL COLLEGE OF GEORGIA, AUGUSTA 30912
SMITH, C.C. 54 ACT D
1345 DRUID PARK AVE, AUGUSTA 30904
SMITH, DENNIS B. 54 ACT N
VA HOSPITAL, AUGUSTA 30904
SMITH, DIANE K. 54 ACT IM
MEDICAL COLLEGE OF GA BD 101, AUGUSTA 30912
SMITH, EDWARD H., JR. 54 ACT D
1021-15TH ST, AUGUSTA 30901
SMITH, J. GRAHAM 54 ACT D
MEDICAL COLLEGE OF GEORGIA, AUGUSTA 30912
SMITH, R. LOUIE 54 ACT GE
1514 ANTHONY RD, AUGUSTA 30904
SMITH, RANDOLPH R. 54 ACT PS
820 ST SEBASTIAN WAY, AUGUSTA 30902
SMITH, STANLEY T., JR. 54 ACT
820 ST SEBASTIAN WAY, AUGUSTA 30904
SMOAK, HUBERT W., JR. 54 ACT AN
VA MEDICAL CENTER, AUGUSTA 30910
SO, ELSON L. 54 ACT N
VA MEDICAL CENTER, AUGUSTA 30910
SPEIR, WILLIAM A., JR. 54 ACT PUD
1120-15TH ST, AUGUSTA 30912
STEED, WILLIAM A. 54 ACT OTO
1122 DRUID PARK AVE, AUGUSTA 30904
STEELE, JOHN C.H., JR. 54 ACT PTH
MEDICAL COLLEGE OF GEORGIA, AUGUSTA 30912
STILL, JOSEPH M., JR. 54 ACT PS
PO BOX 3726, AUGUSTA 30904
STINCER, ELPIDIO J. 54 ACT IM
3623 J DEWEY GRAY CIR STE D, AUGUSTA 30909
STOCKS, S. ALLAN 54 ACT OPH
1514 ANTHONY RD, AUGUSTA 30904
STODDARD, LELAND D. 54 ACT PTH
MEDICAL COLLEGE OF GEORGIA, AUGUSTA 30912
STORY, FRANK CRAWFORD, JR. 54 ACT OBG
1505 WINTER ST, AUGUSTA 30904
STORY, STACY H., III 54 ACT AN
BOX 3881 HILL STA, AUGUSTA 30909
STRONG, WILLIAM B. 54 ACT PDC
MEDICAL COLLEGE OF GEORGIA, AUGUSTA 30912
SULLIVAN, DANIEL B. 54 ACT GS
1430 HARPER ST, AUGUSTA 30902
SULLIVAN, HUMBERT G. 54 ACT NS
MEDICAL COLLEGE OF GEORGIA, AUGUSTA 30912
SUSSMAN, HY C. 54 ACT IM
820 ST SEBASTIAN WAY SE, AUGUSTA 30902
SWIFT, THOMAS R. 54 ACT N
MEDICAL COLLEGE OF GEORGIA, AUGUSTA 30912
TALLEDO, O. EDUARDO 54 ACT OBG
MEDICAL COLLEGE OF GEORGIA, AUGUSTA 30904
TANNER, ROBERT E. 54 ACT PD
3520 WALTON WAY, AUGUSTA 30909
TEDESCO, FRANCIS JOSEPH 54 ACT GE
MEDICAL COLLEGE OF GEORGIA, AUGUSTA 30901
THIGPEN, CORBETT M. 54 ACT ORS
HUMANA MEDICAL PLAZA STE 210, AUGUSTA 30909
THOMAS, DAVID R., III 54 ACT PUD
820 SAN SEBASTIAN WAY ' 2-B, AUGUSTA 30902
THOMAS, LUTHER M., JR. 54 ACT IM
1500 JOHNS RD, AUGUSTA 30904
THURMOND, A.G. 54 ACT OBG
1012 CAROLINA AVE APT 4, N AUGUSTA SC 29841
THURMOND, GEORGE W. 54 ACT OTO
2283 WRIGHTSBORO RD, AUGUSTA 30904
THURMOND, J.W. 54 ACT OBG
849 OLD EDGEFIELD RD, N AUGUSTA SC 29841
TILLERY, WILLIAM V., III 54 ACT OPH
1514 ANTHONY RD, AUGUSTA 30904
TOLLISON, JOSEPH W. 54 ACT FP
MEDICAL COLLEGE OF GEORGIA, AUGUSTA 30902
TRAN, CHUONG D. 54 ACT GP
3504 POTOMAC DR, AUGUSTA 30906
TREST, FRED A. 54 ACT P
2322 WRIGHTSBORO RD, AUGUSTA 30904
TRINCHER, ROSE C. 54 ACT IM
VA MEDICAL CENTER, AUGUSTA 30904
VAN GIESEN, GEORGE E., JR. 54 ACT IM
1109 MEDICAL CENTER DR ' 4-C, AUGUSTA 30909
VANDERZALM, THEODORA 54 ACT R
MEDICAL COLLEGE OF GEORGIA, AUGUSTA 30912
VARMA, JAYDEV R. 54 ACT FP
MEDICAL COLLEGE OF GEORGIA, AUGUSTA 30912
VENABLE, ROGER J. 54 ACT FP
1417 PENDLETON RD, AUGUSTA 30904
VOLPITTO, P.P. 54 ACT AN
TALMADGE MEMORIAL HOSPITAL, AUGUSTA 30902
WALTERS, GORDON E. 54 ACT IM
1500 JOHNS RD, AUGUSTA 30904
WARD, DANIEL F. 54 ACT EM
MEDICAL COLLEGE OF GEORGIA, AUGUSTA 30912
WATERS, A.J. 54 ACT AN
3405 SASANQUA DR, AUGUSTA 30909
WATKINS, LAURENCE O. 54 ACT IM
MEDICAL COLLEGE OF GEORGIA, AUGUSTA 30912
WATKINS, PATRICIA N. 54 ACT P
1220 GEORGE C WILSON DR, AUGUSTA 30909
WATSON, W.G. 54 ACT OBG
1430 HARPER ST, AUGUSTA 30902
WATTS, MICHAEL A. 54 ACT TS
2100 CENTRAL AVE STE 5, AUGUSTA 30904
WEBSTER, PAUL D., III 54 ACT GE
MEDICAL COLLEGE OF GEORGIA, AUGUSTA 30912
WEEKS, RICHARD B. 54 ACT GS
4230-13TH ST, ST SIMONS IS 31522
WESTON, WILLIAM, III 54 ACT PD
MEDICAL COLLEGE OF GEORGIA, AUGUSTA 30901
WHELCHEL, MERRITT C. 54 ACT OPH
905-15TH ST 'E, AUGUSTA 30902
WHITLOCK, RICHARD R., JR. 54 ACT IM,CD
MEDICAL COLLEGE OF GEORGIA, AUGUSTA 30904
WIER, MARION A. 54 ACT R
PO BOX 10106, AUGUSTA 30903
WIGH, RUSSELL E. 54 R R
3601 BURNING TREE CT, AUGUSTA 30907
WILKES, W.A. 54 ACT PD
1203 HIGHLAND AVE, AUGUSTA 30904
WILLIAMS, DAVID C., JR. 54 ACT U
1142 DRUID PARK, AUGUSTA 30904
WILLIAMS, GEORGE P. 54 ACT OBG
1505 WINTER ST, AUGUSTA 30904
WILLIAMS, JACK B. 54 ACT AN
MEDICAL COLLEGE OF GEORGIA, AUGUSTA 30901
WILLIAMS, JOHN L. 54 ACT NS
820 ST SEBASTIAN WAY, AUGUSTA 30910
WILSON, OHLEN R. 54 ACT FP
3589 OAKMONT CT, MARTINEZ 30907
WITHAM, A. CALHOUN 54 ACT IM
MEDICAL COLLEGE OF GEORGIA, AUGUSTA 30912
WITHERINGTON, ROY 54 ACT U
MEDICAL COLLEGE OF GEORGIA, AUGUSTA 30912
WRAY, BETTY B. 54 ACT PD
MEDICAL COLLEGE OF GEORGIA, AUGUSTA 30902
WRAY, CHARLES H. 54 ACT GS
MEDICAL COLLEGE OF GEORGIA, AUGUSTA 30902
WRIGHT, GEORGE W. 54 ACT GS
2913 BRANSFORD RD, AUGUSTA 30904
WYLIE, M.H. 54 ACT GS
837 CHAFFEE AVE, AUGUSTA 30904
WYLIE, WILLIAM J. 54 ACT IM
837 CHAFEE AVE, AUGUSTA 30904
YAGHMAI, FARIVAR 54 ACT PTH,NA
MEDICAL COLLEGE OF GEORGIA, AUGUSTA 30902
YANCEY, KIM B. 54 I&R D
10845 BUCKNELL DR, WHEATON MD 20902
YOUNT, AVIS B. 54 ACT D
820 ST SEBASTIAN WAY, AUGUSTA 30902
YOUNT, PETER S. 54 ACT D
820 ST SEBASTIAN WAY, AUGUSTA 30902
ZUMBRO, GEORGE L. 54 ACT CDS
820 ST SEBASTIAN WAY STE 2-D, AUGUSTA 30902

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FREEMAN, JAMES C. 55 ACT FP
106 EAST TELEPHONE ST, SYLVANIA 30467
HAWKINS, KATRINE RAWLS 55 ACT FP
PO BOX 518, SYLVANIA 30467
KENT, WILLIAM R. 55 ACT FP
PO BOX 218, SYLVANIA 30467
LANE, MARIAN F. 55 ACT FP
106 EAST TELEPHONE ST, SYLVANIA 30467
SHUMAN, IVY L., JR. 55 ACT FP
211 MIMS RD, SYLVANIA 30467

56—SOUTH GEORGIA

AGUERO, OSCAR E. 56 ACT ORS
2704 NORTH OAK ST BLDG E, VALDOSTA 31602
ALVARADO, ROMULO R. 56 ACT PD
405 COWART AVE, VALDOSTA 31602
ANDERSON, JOHN D. 56 ACT IM
2311 NORTH PATTERSON ST, VALDOSTA 31602
ANDERSON, THOMAS L. 56 ACT PD,NPM
STE 209 PENDLETON RD, VALDOSTA 31602
AUSTIN, G.J., JR. 56 ACT PD
DOCTORS BLDG STE 202, VALDOSTA 31602
BARKER, CHARLES O. 56 ACT FP
2704 NORTH OAK ST BLDG A-2, VALDOSTA 31602
BARTON, DEWEY L. 56 ACT R
2704-D NORTH OAK ST, VALDOSTA 31602
BEALL, AVERY P. 56 ACT IM
2301-C UNIVERSITY DR, VALDOSTA 31602
BECHTEL, H. BERNARD 56 ACT D
2101 NORTH PATTERSON ST, VALDOSTA 31601
BENNETT, VAN B. 56 R IM
RTE 1 BOX 1 COUNTRY CLUB RD, VALDOSTA 31601

BRANCH, DAVID L., JR. 56 ACT ORS
DOCTORS BLDG, VALDOSTA 31602
BRANNEN, J.H. 56 ACT U
401 WOODROW WILSON DR, VALDOSTA 31602
CAMPA, JOSE C. 56 ACT ORS
2704 OAK ST BLDG B-3, VALDOSTA 31602
CARPENTER, R.S. 56 ACT GS
2533 NORTH ASHLEY, VALDOSTA 31602
CHISHOLM, LEWIS F. 56 ACT FP
305 WEST PLANT AVE, HOMERVILLE 31634
COLEMAN, FRANCIS W. 56 ACT IM
501 WOODROW WILSON DR, VALDOSTA 31602
CORKER, FRANK T. 56 ACT OM
2704 NORTH OAK ST BLDG N, VALDOSTA 31602
CREECH, EARL L. 56 ACT ORS
PO BOX 3117, VALDOSTA 31601
DAVIS, BYRON S. 56 ACT PTH
PO BOX 2658, VALDOSTA 31602
DAVIS, T. ALBERT 56 ACT P
PO BOX 3135, VALDOSTA 31601
DENNARD, JAMES E. 56 ACT OTO
DOCTORS BLDG STE 108, VALDOSTA 31602
DICKSON, WILLIAM A. 56 ACT FP
PO BOX 608, HAHIRA 31632
DIJAMCO, ALICE L. 56 ACT AN
5675 PEACHTREE-DUNWOODY RD, ATLANTA 30342
DRURY, WILEY L. 56 ACT AN
PO BOX 1727, VALDOSTA 31602
DURRANI, FAUZIA K. 56 ACT PD
107 WOODROW WILSON DR, VALDOSTA 31602
ELDRIDGE, F.G. 56 ACT R
2307 RIVERHILL DR, VALDOSTA 31602
FELDMAN, DANIEL M. 56 ACT PD
2000 NORTH PATTERSON ST, VALDOSTA 31602
GEE, W.N., JR. 56 ACT IM,GE
401 EAST JANE ST, VALDOSTA 31601
GETMAN, THOMAS A. 56 ACT EM
209 EAST MAIN ST, HAHIRA 31632
GIDDENS, I.S. 56 ACT FP
804 WEST MAIN ST, LAKELAND 31635
GREER, MACK V. 56 ACT FP
VSC INFIRMARY, VALDOSTA 31698
GROW, WILLIAM R. 56 ACT IM
PO BOX 3115, VALDOSTA 31602
HATCH, JOSEPH C. 56 ACT GS
SEMINOLE SQ COND, SEMINOLE FL 33542
HIROMOTO, JESUS H. 56 ACT NS
2704 NORTH OAK ST BLDG L, VALDOSTA 31602
HOBBY, CHARLES F. 56 ACT R
2704-D NORTH OAK ST, VALDOSTA 31602
HODGES, CHARLES A., JR. 56 ACT AN
PO BOX 1727, VALDOSTA 31602
HUNT, JOHN B. 56 ACT U
401 WOODROW WILSON DR, VALDOSTA 31602
JOHNSON, A.M. 56 ACT PD
1612 NORTH OAK ST, VALDOSTA 31601
LAWSON, QUENTIN T. 56 ACT U
401 WOODROW WILSON DR, VALDOSTA 31602
LIGHT, GERALD S. 56 ACT PD
2704 NORTH OAK BLDG J, VALDOSTA 31602
LITTLE, ALEX G., JR. 56 R GS
RTE 1 BOX 4, VALDOSTA 31601
LOEFFLER, JANICE H. 56 ACT PD
2704 NORTH OAK ST, VALDOSTA 31602
MALIK, ANWAR K. 56 ACT PD
104 WOODROW WILSON, VALDOSTA 31602
MATHIS, JAMES W. 56 ACT GS
2704 NORTH OAK ST, VALDOSTA 31602
MCRAE, ANDREW THOMAS 56 ACT GS
2704 NORTH OAK ST, VALDOSTA 31602
MEADORS, JASON LAWRENCE 56 ACT R
2704-D NORTH OAK ST, VALDOSTA 31602
MILLER, J.M. 56 ACT OBG
2307 NORTH PATTERSON ST, VALDOSTA 31602
MIRATE, DONALD J. 56 ACT OPH
STE 207 DOCTORS BLDG, VALDOSTA 31602
MIXSON, E. HARRY 56 ACT GP
DOCTORS BLDG, VALDOSTA 31602
MIXSON, JOYCE F., JR. 56 ACT OBG
105 DOCTORS BLDG, VALDOSTA 31602
MOSELEY, THOMAS H. 56 ACT OBG
DOCTORS BLDG, VALDOSTA 31602
MOSELEY, THOMAS H., JR. 56 ACT OBG
2704 NORTH OAK ST, VALDOSTA 31602
MOYE, BEN H. 56 ACT OPH
3024 NORTH PATTERSON ST, VALDOSTA 31602
NELSON, FRED L., JR. 56 ACT R
PO BOX 308, NASHVILLE 31639
NIJEM, RICHARD J. 56 ACT IM
PO BOX 1086, VALDOSTA 31601
NIJEM, WILLIAM 56 ACT CD,IM
PO BOX 1086, VALDOSTA 31601
NUTT, RICHARD LAMAR 56 R AN
RTE 8 BOX 63, VALDOSTA 31601
PARROTT, JESSE LYLE 56 ACT FP
204 EAST LAWSON ST STE 102, HAHIRA 31632
PULIDD, QUINTIN M. 56 ACT GS
101 WOODROW WILSON DR, VALDOSTA 31602
PURVIS, JERRY G. 56 ACT GS
106 WEST NORTHSIDE DR, VALDOSTA 31602
QUATTLEBAUM, ROBERT B. 56 ACT R
2704-D NORTH OAK ST, VALDOSTA 31602
RAVELO, FRANCISCO JOSE 56 ACT PTH
3914 FOXBOROUGH BLVD, VALDOSTA 31602
RENN, WADE H. 56 ACT NS
200 EAST GORDON ST, VALDOSTA 31601
RETTERBUSH, DAVID W. 56 ACT GS
PO BOX 2313, VALDOSTA 31602
RETTERBUSH, W.C. 56 ACT GS
BOX 2313, VALDOSTA 31604
SALANGA, ROGELIO B. 56 ACT GS
PO BOX 908, NASHVILLE 31639
SANTOS, TEODORO DE LOS 56 ACT PTH
PO BOX 1727, VALDOSTA 31601
SHERMAN, HENRY T. 56 ACT IM
604 GEORGIA AVE, VALDOSTA 31601
SMITH, FRANK Q. 56 ACT OBG
PO BOX 2748, VALDOSTA 31604
SMITH, FRED C. 56 ACT GS
101 WEST NORTHSIDE DR, VALDOSTA 31602
SMITH, HENRY BRIGGS 56 ACT OTO
DOCTORS BLDG, VALDOSTA 31602
SMITH, THOMAS H., JR. 56 ACT OPH
3024 NORTH PATTERSON ST, VALDOSTA 31602
STEWART, BETTY G. 56 ACT P,N
PO BOX 1804, VALDOSTA 31601
STUBBS, JOE C. 56 ACT IM
101 NORTHSIDE DR, VALDOSTA 31602
STUMP, ROBERT L., JR. 56 ACT FP
1624 BOONE DR, VALDOSTA 31602
TAORMINA, FRANK E. 56 ACT CDS
PO BOX 3132, VALDOSTA 31601
THOMPSON, EMORY F. 56 ACT OPH
PO BOX 3193, VALDOSTA 31601
THRELKELD, WILLIAM A. 56 ACT P
PO BOX 1727, VALDOSTA 31601
TOVAR-DE-HOYOS, MANUEL 56 ACT FP
301 WOODROW WILSON DR, VALDOSTA 31602
WINSTON, R.K. 56 ACT OPH
DOCTORS BLDG, VALDOSTA 31602
WOODWARD, BOLAN P. 56 ACT OBG
2704 NORTH OAK ST, VALDOSTA 31602
YOULES, OWEN K., JR. 56 ACT OBG
2704 NORTH OAK ST BLDG G, VALDOSTA 31602

57—SOUTHEAST GEORGIA

BARFIELD, JAMES E. 57 ACT GP
PO BOX 1187, VIDALIA 30474
BARNARD, BENJAMIN C. 57 ACT FP
PO BOX 1127, VIDALIA 30474
BEDINGFIELD, W.H. 57 ACT FP
PO BOX 629, VIDALIA 30474
CLARK, ROBERT B., JR. 57 ACT GP,GS
PO BOX 367, VIDALIA 30474
CONNER, H.I. 57 ACT GS
PO BOX 1107, VIDALIA 30474
DEJARNETTE, ROBERT H., JR. 57 ACT GS
702 MEADOWS LN, VIDALIA 30474
DRAKE, CHARLES H. 57 ACT FP
707 EAST MARIETTA ST, GLENNVILLE 30427
JELKS, LOUIS R. 57 ACT GS
PO BOX 128, REIDSVILLE 30453
KALATHOOR, J.R. 57 ACT AN
PO BOX 1303, VIDALIA 30474
KALATHOOR, PARANDHAMA R. 57 ACT U
PO BOX 1303, VIDALIA 30474
MCARTHUR, JOHN D. 57 ACT GS
601 NORTH LANIER ST, LYONS 30436
MCNAIR, WILLIAM P. 57 ACT FP
115 SECOND ST S, SOPERTON 30457
MERRITT, GEORGE W. 57 ACT FP
PO BOX 1187, VIDALIA 30474
MORRIS, A.J. 57 ACT GS
PO BOX 1328, VIDALIA 30474
RAO, VARALAKSHMI N. 57 ACT OBG
PO BOX T, VIDALIA 30474
RENTZ, TURNER W., SR. 57 ACT
205 WEST MAIN, COLQUITT 31737
RIMANDO, LEONARDO F. 57 ACT GS
PO BOX 1185, VIDALIA 30474
SANTIAGO, ARMANDO 57 ACT GP
401 WEST BROAD ST, LYONS 30436
SUBER, HUBERT 57 ACT OBG
PO BOX 30, VIDALIA 30474
WEAVER, RICHARD J. 57 ACT PTH
PO BOX 1343, VIDALIA 30474
YATES, A.J., JR. 57 ACT FP
PO BOX 477, SOPERTON 30457

58—SOUTHWEST GEORGIA

CROWDIS, JAMES H., JR. 58 ACT GP
PO BOX 547, BLAKELY 31723
JENNINGS, ROBERT E. 58 ACT FP
ARLINGTON CITY HOSPITAL, ARLINGTON 31713
LASSITER, HOMER L. 58 ACT FP
ARLINGTON CITY HOSPITAL, ARLINGTON 31713
MERRITT, BRADLEY SAUNDERS 58 ACT IM
208 NORTH CUTHBERT ST, COLQUITT 31737
MONTES, ISMAEL G. 58 ACT GS
PO BOX 114, COLQUITT 31737
SAXENA, VIRENDRA M. 58 ACT GS
PO BOX 54, FT GAINES 31751
VAZQUEZ, JOSEPH G. 58 ACT FP,EM
PO BOX 429, BLAKELY 31723
WETHERBY, DAVID 58 ACT
BOX 128 WASHINGTON ST, FT GAINES 31751
WOOD, HOMER P. 58 ACT FP
CLAY COUNTY HOSPITAL, FT GAINES 31751

59—SPALDING

AUSTIN, J.L. 59 ACT OTO

BARNES, STEPHEN N. 59 ACT ORS
610 SOUTH EIGHTH ST, GRIFFIN 30223
BLACK, GRADY E. 59 ACT PD
567 SOUTH NINTH ST, GRIFFIN 30223
BLANCHARD, HUBERT H. 59 ACT P
BRIGHTMOOR NURSING HOME, GRIFFIN 30223
BRANDON, R.V. 59 ACT FP
WESTBURY MED CARE HOME, JENKINSBURG 30234
BROWN, GEORGE W. 59 ACT R
686 SOUTH EIGHTH ST, GRIFFIN 30223

CHEWNING, RICHARD D. 59 ACT OBG
503 SOUTH EIGHTH ST, GRIFFIN 30223
CLOUSE, JOHN E., JR. 59 ACT FP
655 BROOK CIR, GRIFFIN 30223
CDLVIN, WILLIAM S. 59 ACT PD
666 SOUTH EIGHTH ST, GRIFFIN 30223
CDOPER, FLOYD C., III 59 ACT P
324 SOUTH 12TH ST, GRIFFIN 30223
COX, JDEL E. 59 ACT OBG
503 SOUTH EIGHTH ST, GRIFFIN 30223
CRAWFDRD, JOHN B. 59 ACT FP
10 MARKET ST, BARNESVILLE 30204
DAY, JAMES D., III 59 ACT IM
231 GRAEFE ST, GRIFFIN 30223
DI CRISTINA, MICHAEL A. 59 ACT IM
571 SOUTH NINTH ST, GRIFFIN 30223
DUKE, GRADY F. 59 ACT GS
205 GRAEFE ST, GRIFFIN 30223
DUNAWAY, JAMES B. 59 ACT PD
666 SOUTH EIGHTH ST, GRIFFIN 30223
FLOYD, T.J., JR. 59 R GS
543 BROOK CIR, GRIFFIN 30223
FOSTER, HENRY A. 59 ACT FP
319 SOUTH NINTH ST, GRIFFIN 30223
GEIGER, HUGH S. 59 ACT
PO BOX 3987, JACKSON 30233
HAJDSY, RALPH W. 59 ACT ORS
616 SOUTH EIGHTH ST, GRIFFIN 30223
HENRY, GEORGE T. 59 ACT FP
TAYLOR ST, BARNESVILLE 30204
HUNT, THOMAS JEFFERSON 59 ACT GS
610 SOUTH EIGHTH ST, GRIFFIN 30223
KELLEY, J. WELDON 59 ACT GS
602 SOUTH EIGHTH ST, GRIFFIN 30223
KING, JDHN LAMAR 59 ACT U
653 SOUTH EIGHTH ST, GRIFFIN 30223
KING, WILLIAM R., JR. 59 ACT GS
708 SOUTH EIGHTH ST, GRIFFIN 30223
KREPPS, ARTHUR C., II 59 ACT OBG
503 SOUTH EIGHTH ST, GRIFFIN 30223
KWDK, KEN K. 59 ACT FP
PO BOX 561, ZEBULON 30295
LANDHAM, JACKSON W., JR. 59 ACT IM
743 SOUTH EIGHTH ST, GRIFFIN 30223
LINDYBERG, KENNETH R. 59 S GS
600 SOUTH 8TH ST, GRIFFIN 30223
MACIAS, F.M. 59 ACT AN
24 MAIN ST, HAMPTON 30228
MAPLES, RUSSELL V. 59 ACT IM,PUD
23L GRAEFE ST, GRIFFIN 30223
MONTERO, ENRIQUE 59 ACT AN
546 SOUTH EIGHTH ST, GRIFFIN 30223
OSHLAG, ABRAHAM M. 59 ACT IM
718 SOUTH EIGHTH ST, GRIFFIN 30223
PATEL, MANHARBHAI N. 59 ACT GS
610 SOUTH EIGHTH ST, GRIFFIN 30223
PATEL, SUMANTKUMAR 59 ACT IM
691 SOUTH EIGHTH ST, GRIFFIN 30223
REMINGTON, DAVE B. 59 ACT CD
116 WEST POPLAR ST, GRIFFIN 30223
REYNDLDS, KENNETH H. 59 ACT IM
231 GRAEFE ST, GRIFFIN 30223
SKINNER, JAMES M. 59 ACT OBG
610 SOUTH EIGHTH ST, GRIFFIN 30223
SMITH, THEODORE 59 ACT OBG
PO BOX 3877, JACKSON 30233
SMITH, WILLIAM V. 59 ACT OBG
503 SOUTH EIGHTH ST, GRIFFIN 30223
STUCKEY, ANN D. 59 ACT PD
718 SOUTH EIGHTH ST, GRIFFIN 30223
TAKLE, LEIV M. 59 ACT OPH
646 SOUTH EIGHTH ST, GRIFFIN 30223
TATUM, L.L, JR. 59 ACT U
653 SOUTH EIGHTH ST, GRIFFIN 30223
TRAYLOR, S.B. 59 ACT FP
MAIN ST, BARNESVILLE 30204
WALKER, GEORGE L. 59 R IM
330 EAST COLLEGE ST APT 106, GRIFFIN 30223
WILLIAMS, VIRGIL B. 59 ACT GS
505 BROOKWOOD TERR, GRIFFIN 30223
ZEVALLOS, CARLOS A. 59 ACT PTH
SPALDING CITY HOSPITAL, GRIFFIN 30223

60—STEPHENS-RABUN

AHMAD, AMBREEN A. 60 ACT P
PO BOX 372, TOCCOA 30577
AHMAD, NASEER 60 ACT PTH
759 HENDERSON FALLS RD, TOCCOA 30577
AHRANO, JUDITH 60 ACT PD
800 EAST DOYLE ST, TOCCOA 30577
BANNISTER, PHILLIP N. 60 ACT OBG
800 EAST DOYLE ST, TOCCOA 30577
BLADDWSKI, JOHN R. 60 ACT OTO
800 EAST DOYLE ST, TOCCOA 30577
CONOLEY, KENNETH 60 ACT PD
800 EAST DOYLE ST, TOCCOA 30577
COPELAN, ELTON L. 60 ACT OBG
PO BOX 788, TOCCOA 30577
DAVIS, TERRELL L. 60 ACT PD
PO BOX 1284, CLAYTON 30525
DAWS, ANTHONY WAYNE 60 ACT GS
FALLS RD PROF PARK, TOCCOA 30577
DESIMONE, JOHN W. 60 ACT FP
800 EAST DOYLE ST, TOCCOA 30577
DOSS, MELVIN C. 60 ACT FP
800 EAST DOYLE ST, TOCCOA 30577
FOWLER, JDHN E., MD FAAFP 60 ACT FP
PO BOX 825, CLAYTON 30525
GILBERT, CLYDE D. 60 ACT OBG
800 EAST DOYLE ST, TOCCOA 30577
HAY, S.H. 60 ACT IM
EAST DOYLE ST, TOCCOA 30577
HELLENGA, IRVING D. 60 ACT FP
TOCCOA CLINIC, TOCCOA 30577
KING, GEORGE C. 60 ACT FP
BOX 1209, CLAYTON 30525
KISTLER, HENRY E. 60 ACT OBG
905 BIG A RD, TOCCOA 30577
KITCHIN, HOUSTON W. 60 R GP
RTE 2 BOX 2354, CLAYTON 30525
LAMPROS, C. PETER 60 ACT R
800 DOYLE ST, TOCCOA 30577
LAWRENCE, JDHN C. 60 ACT PD
800 EAST DOYLE ST, TOCCOA 30577
LEE, FRED M. 60 ACT U
800 EAST DOYLE ST, TOCCOA 30577
PATCH, DAVID W. 60 ACT ORS
PO BOX 609, TOCCOA 30577
PATEL, MAHENDRA M. 60 ACT R
800 EAST DOYLE ST, TOCCOA 30577
PAULY, RDBERT P. 60 ACT GS
PO BOX 609, TOCCOA 30577
PAYTON, JOHN A. 60 ACT FP
800 E DOYLE ST, TOCCOA 30577
PICKENS, JAMES C. 60 ACT OBG
800 EAST DOYLE ST, TOCCOA 30577
PITTARD, M.D. 60 ACT FP
800 EAST DOYLE ST, TOCCOA 30577
REED, RALPH EUGENE 60 ACT OPH
800 EAST DOYLE ST, TOCCOA 30577
RICHARDSON, JAMES W. 60 ACT EM
STEPHENS COUNTY HOSPITAL, TOCCOA 30577
SETZER, EDWARD H. 60 ACT IM
800 EAST DOYLE ST, TOCCOA 30577
SINGER, ARTHUR G. 60 ACT R
800 EAST DOYLE ST, TOCCOA 30577
SLATE, ROBERT W. 60 ACT GS
PO BOX 609, TOCCOA 30577
THOMPSON, RDBERT E. 60 ACT FP
800 EAST DOYLE ST, TOCCOA 30577
TURNER, RICHARD J. 60 ACT FP
PO BOX 746, CLAYTON 30525
VARNADDRE, J. GREG 60 ACT FP
PO BOX 1268, TOCCOA 30577
WADE, JIM R. 60 ACT IM
800 EAST DOYLE ST, TOCCOA 30577

61—SUMTER

ANDERSON, W.R. 61 ACT PD
PO BOX 568, AMERICUS 31709
BROUN, PAUL C., JR. 61 ACT FP
1102 EAST LAMAR ST, AMERICUS 31709
BURROUGHS, FLEMING 61 ACT IM
PO BOX 1717, AMERICUS 31709
CAMPBELL, ROBERT D. 61 ACT FP
1102 EAST LAMAR ST, AMERICUS 31709
CHENG, YUEH Y. 61 ACT PD
PO BOX 485, AMERICUS 31709
DUDLEY, A.G. 61 ACT OBG
401 SOUTH LEE ST, AMERICUS 31709
DUDLEY, JAMES C. 61 ACT GS
629 EAST FORSYTH ST, AMERICUS 31709
GATEWDOD, T. SCHLEY 61 ACT OBG
205 SOUTH LEE ST, AMERICUS 31709
GATEWOOD, T. SCHLEY, JR. 61 ACT OBG
205 SOUTH LEE ST, AMERICUS 31709
HERRON, JAMES G. 61 ACT IM
1102 EAST LAMAR AVE, AMERICUS 31709
HO, RAYMOND C. 61 ACT PD
PO BOX 248, AMERICUS 31709
LDPEZ, AUGUSTO 61 ACT PTH
AMERICUS-SUMTER CO HOSP, AMERICUS 31709
MAYS, WALLACE D. 61 ACT OBG
401 SOUTH LEE ST, AMERICUS 31709
MCDANIEL, F. ELLEN 61 ACT DR
AMERICUS/SUMTER CO HOSPITAL, AMERICUS 31709
PATEL, BHARAT J. 61 ACT U
629 EAST FORSYTH ST, AMERICUS 31709
PATEL, NINNA B. 61 ACT OTO
PO BOX 805, AMERICUS 31709
ROBINSON, JOHN H., III 61 ACT GS
629 EAST FORSYTH ST, AMERICUS 31709
RUNDLE, T.J. 61 ACT OPH
PO BOX 1026, AMERICUS 31709
SAVAGE, C.P. 61 ACT FP
524 SUMTER ST, MONTEZUMA 31063
SIMPSON, HARVEY L. 61 ACT GS
1102 LAMAR ST, AMERICUS 31709
STEINER, ALBIN H. 61 ACT R
701 EAST LAMAR ST, AMERICUS 31709
STOREY, GEDRGE M. 61 ACT ORS
629 EAST FORSYTH ST, AMERICUS 31709
TAYLOR, GERALD J. 61 ACT P
712 EAST FORSYTH, AMERICUS 31709
TAYLOR, NEILL O. 61 ACT OBG
205 SOUTH LEE ST, AMERICUS 31709
TEAFORD, HENRY S., JR. 61 ACT GS
BOX 787, AMERICUS 31709
THOMAS, RUSSELL 61 ACT GP
LESLIE RD, AMERICUS 31709
THDMPSDN, F.H. 61 ACT PTH
712 EAST FORSYTH ST, AMERICUS 31709
VASKO, TRUMAN L. 61 ACT GS
PO BOX 247, VIENNA 31092
WALDEMAYER, E.W. 61 ACT FP
3222 BARKSIDE CT, CHAMBLEE 30341
WILSON, FRANK A., III 61 ACT IM
PO BOX 247, LESLIE 31764

62—ST. JOHN'S PARISH

BAUTISTA, GRACE C. 62 ACT PD
214 FRASER DR, HINESVILLE 31313

BAUTISTA, VICTOR C. 62 ACT AN
PO BOX 87, MIDWAY 31320
CARTER, ROBERT GLENN 62 ACT IM
303 FRASER DR, HINESVILLE 31313
FRASER, WHITMAN 62 ACT FP
PO BOX 406, HINESVILLE 31313
ONG, ANTONIO L. 62 ACT FP
PO BOX 764, HINESVILLE 31313
ONG, CECILIA B. 62 ACT PD
214 FRASER DR, HINESVILLE 31313
SHIH, CHEN-WEN 62 ACT OBG
212 FRASER DR, HINESVILLE 31313
SILAN, J. RUBEN D. 62 ACT GS
PO BOX 844, HINESVILLE 31313

65—THOMAS AREA

ARNETT, THOMAS E. 65 ACT OBG
706 SOUTH BROAD ST, THOMASVILLE 31792
BEESON, J. DANIEL 65 ACT AN
908 EAST WASHINGTON ST, THOMASVILLE 31792
BELL, RUDOLPH 65 ACT U
PO BOX 1675, THOMASVILLE 31792
BOSWELL, W.C. 65 ACT PD
4246 OLD CLUB RD EAST, MACON 31210
BRIDGES, WILLIAM Z. 65 ACT OPH
808 GORDON AVE, THOMASVILLE 31792
BRINSON, JOHN B., JR. 65 ACT FP
503 GORDON AVE, THOMASVILLE 31792
BYRD, JEFF W. 65 ACT PTH
JD ARCHBOLD MEM HOSPITAL, THOMASVILLE 31792
CAIN, ROBERT T. 65 ACT FP
PO BOX 231, QUITMAN 31643
CARICO, JAMES M. 65 ACT R
PO BOX 736, THOMASVILLE 31792
CARPENTER, PAUL R. 65 ACT DR
113 WEST HANSELL ST, THOMASVILLE 31792
CHENEY, HUDDIE L. 65 ACT IM
PO BOX 1099, THOMASVILLE 31792
CHRISTENSEN, EUNICE H. 65 R AN
PO BOX 1096, THOMASVILLE 31792
COURSON, HERMAN C. 65 ACT IM
PO BOX 1939, THOMASVILLE 31792
DUNAWAY, MARSHALL C. 65 ACT IM
808 GORDON AVE, THOMASVILLE 31792
ELY, RALPH L. 65 ACT GS
114 MIMOSA DR, THOMASVILLE 31792
FALBAUM, HARTLEY L. 65 ACT ORS
PO BOX 1957, THOMASVILLE 31792
GALL, HENRY 65 ACT PD
PO BOX 502, CAIRO 31728
HANCOCK, S.L. 65 ACT US
35 14TH AVE NW, CAIRO 31728
HANEY, MICHAEL L. 65 ACT OPH
808 GORDON AVE, THOMASVILLE 31792
HODGES, C. HUBERT, JR. 65 ACT U
BOX 1576, THOMASVILLE 31792
HOWARD, LEONARD F. 65 ACT FP
DOCTORS PK, CAIRO 31728
JACKSON, ROBERT W., DDS 65 AF GS
PO BOX 1696, THOMASVILLE 31792
JARRETT, EUGENE C., III 65 ACT PD
SOUTHWESTERN STATE HOSP, THOMASVILLE 31792
KADIS, GERALD N. 65 ACT NS
704 SOUTH BROAD ST, THOMASVILLE 31792
KARSH, RICHARD B. 65 ACT R,PDC
113 WEST HANSEL ST, THOMASVILLE 31792
KING, JOHN T., JR. 65 ACT OPH
PO BOX 1919, THOMASVILLE 31792
LANE, GEORGE M. 65 ACT R
PO BOX 736, THOMASVILLE 31792
LARDIN, WILLIAM A. 65 ACT AN
ARCHBOLD MEM HOSPITAL, THOMASVILLE 31792
LEAR, THOMAS F., JR. 65 ACT GS
PO BOX 1912, THOMASVILLE 31792
LEE, LOUIS G. 65 ACT IM,GE
503 GORDON AVE, THOMASVILLE 31792
LITTLE, FRANK A. 65 R AN
109 TUXEDO DR, THOMASVILLE 31792
MALONE, RANDOLPH A. 65 ACT PD
509 GORDON AVE, THOMASVILLE 31792
MAXWELL, ROBERT B. 65 ACT PD
509 GORDON AVE, THOMASVILLE 31792
MCCOLLUM, WILLIAM 65 ACT PTH
ARCHBOLD MEM HOSPITAL, THOMASVILLE 31792
MCKENZIE, DONALD J. 65 ACT U
935 SOUTH BROAD ST, THOMASVILLE 31792
MCNAIR, GEORGE 65 ACT AN
JD ARCHBOLD MEM HOSPITAL, THOMASVILLE 31792
MIDDLETON, MILTON G. 65 ACT P
MENTAL HEALTH CENTER, THOMASVILLE 31792
MILLER, FRANK R. 65 ACT PD
509 GORDON AVE, THOMASVILLE 31792
MIMS, OSCAR M. 65 ACT IM
900 GORDON AVE, THOMASVILLE 31792
MORTON, WILLIAM J. 65 ACT FP
220 FIRST ST SE, CAIRO 31728
MULLER, GERALD B. 65 ACT OBG
918 SOUTH BROAD ST, THOMASVILLE 31792
NEILL, JAMES ROBERT 65 ACT IM
918 SOUTH BROAD ST, THOMASVILLE 31792
PAYNE, JOHN F. 65 ACT ORS
106 EUCLID DR, THOMASVILLE 31792
PEDERSON, ROBERT A. 65 ACT
704 SOUTH BROAD ST, THOMASVILLE 31792
PEPIN, HENRY S. 65 ACT FP
602 EAST SEIXAS ST, THOMASVILLE 31792
RAWLINGS, JOE D. 65 ACT FP
PO BOX 1617, THOMASVILLE 31792
REYNOLDS, G. THOMAS 65 ACT OBG
918 SOUTH BROAD ST, THOMASVILLE 31792
ROMINE, BENJAMIN W. 65 ACT FP
PO BOX 232, QUITMAN 31643
RUPAREL, HARESH M. 65 ACT IM
PO BOX 845, QUITMAN 31643
SHEALY, L.M. 65 ACT FP
PO BOX 631, QUITMAN 31643
SHEPARD, KIRK 65 ACT GS
204 JUNIUS ST, THOMASVILLE 31792
SLAUGHTER, WILLIAM G. 65 ACT P
228 GORDON AVE, THOMASVILLE 31792
SPANN, CHARLES G. 65 ACT AN
1321 GORDON AVE, THOMASVILLE 31792
STORY, JAMES L., JR. 65 ACT GS
505 GORDON AVE, THOMASVILLE 31792
STRESE, FRITZ W. 65 ACT FP
ARCHBOLD MEM HOSPITAL, THOMASVILLE 31792
TANNER, MAURICE B. 65 ACT R
PO BOX 736, THOMASVILLE 31792
TAYLOR, JAMES P. 65 ACT OBG
507 GORDON AVE, THOMASVILLE 31792
TAYLOR, WARREN A. 65 ACT GS
PROF BLDG SIEXAS ST, THOMASVILLE 31792
THOMPSON, WILLIAM A. 65 ACT OBG
706 SOUTH BROAD ST, THOMASVILLE 31792
WARD, TIMOTHY H. 65 ACT AN
211 GREENLEAF TERR, THOMASVILLE 31792
WATT, CHARLES H., JR. 65 ACT GS
900 GORDON AVE, THOMASVILLE 31792
WATT, WILLIAM V. 65 ACT GS,GE
900 GORDON AVE, THOMASVILLE 31792
WINE, MERVIN B. 65 ACT A
602 EAST SEIXAS ST, THOMASVILLE 31792
WOOD, MARK G. 65 ACT NEP
114 MIMOSA DR, THOMASVILLE 31792
ZAVALETA, A.A. 65 ACT TS
505 GORDON AVE, THOMASVILLE 31792

66—TIFT

CARTER, YANCEY FRANKLIN 66 ACT GP
1223 EAST MCPHERSON, NASHVILLE 31639
CHIANG, MIKE S. 66 ACT U
1615 JOHN ORR DR, TIFTON 31794
CLEMENTS, FRED N. 66 ACT FP
807 NORTH PARRISH AVE, ADEL 31620
DAVIS, F. MORRIS 66 ACT FP
820 TIFT AVE, TIFTON 31794
DAVIS, LAWRENCE P. 66 ACT GS
875 LAKESHORE DR, DULUTH 30136
DISMUKE, JAMES C. 66 ACT FP
PO BOX 307, ADEL 31620
DIXON, SAMMIE 66 ACT OBG
PO BOX 1647, TIFTON 31794
DORMINEY, HENRY C., JR. 66 ACT AL
1409-B TIFT AVE, TIFTON 31794
DORMINY, JOHN H., III 66 ACT OBG
PO BOX 1628, TIFTON 31794
EDMONDSON, MICHAEL L. 66 ACT OBG
2205 MADISON AVE, TIFTON 31794
EDMONDSON, T.L. 66 ACT FP
PO BOX 827, TIFTON 31794
EVANS, RAYMOND C. 66 ACT R
PO BOX 388, TIFTON 31793
FLOWERS, EUGENE MONROE 66 ACT FP
PO BOX 86, TIFTON 31794
FORRESTER, EDWARD S., JR. 66 ACT ORS
1610 JOHN ORR DR, TIFTON 31794
GILBERT, STEWART D. 66 ACT R
PO BOX 388, TIFTON 31794
HAYES, T. WILLIAM 66 ACT OTO
PO BOX 1565, TIFTON 31794
HAYNES, RALEIGH R. 66 ACT AN
1607 JOHN OPP DR, TIFTON 31794
HESTER, JESSE D. 66 ACT OBG
PO BOX 1608, TIFTON 31793
HOLLOWAY, WILMER O. 66 ACT R
PO BOX 388, TIFTON 31794
HOLT, EDWARD 66 AC FP
PO BOX 549, ADEL 31620
HORNBACK, WILLIAM L., III 66 ACT ORS
PO BOX 1368, TIFTON 31793
HUGHES, RONALD M. 66 ACT OPH
PO BOX 986, TIFTON 31794
JACOBS, CECIL F. 66 ACT EM
PO BOX 90, PORTAL 30450
KARSTEN, MIKELL B. 66 ACT GS
PO BOX 929, TIFTON 31794
KING, WILLIAM D. 66 ACT OBG
PO BOX 367, TIFTON 31794
KIRKPATRICK, J.F., JR. 66 ACT GS
PO BOX 929, TIFTON 31794
MARTINEZ, MARCIAL E. 66 ACT R
PO BOX 3216, VALDOSTA 31601
MCCULLOUGH, RICHARD E. 66 ACT IM
BOX 947, TIFTON 31794
MOORMAN, LARRY R. 66 ACT OPH
1803 OLD OCILLA RD, TIFTON 31794
MORGAN, ROBERT T. 66 ACT EM
PO BOX 672, ADEL 31620
PFISTER, WILLIAM C. 66 ACT PTH
PO BOX 747, TIFTON 31793
PITTMAN, CARL S. 66 ACT FP
820 TIFT AVE, TIFTON 31794
PITTMAN, CARL S., JR. 66 ACT FP
820 TIFT AVE, TIFTON 31794
RICHBOURG, HENRY R. 66 ACT FP
1223 EAST MCPHERSON, NASHVILLE 31639
RIGDON, STEVEN W. 66 ACT IM
712 EAST 18TH ST, TIFTON 31794
ROBERTS, DON W. 66 ACT IM
PO BOX 947, TIFTON 31793
SAPP, GERALD L. 66 ACT ORS
PO BOX 1368, TIFTON 31793
SCOTT, JAMES W. 66 ACT ORS
PO BOX 1827, TIFTON 31793
SHAH, INDRA C. 66 ACT IM
1801 OLD OCILLA RD, TIFTON 31794

SMITH, DON T. 66 ACT FP
BOX 1348, TIFTON 31794
SMITH, ROBLEY D. 66 ACT FP
PO BOX 788, TIFTON 31794
THOMAS, DENNIS R. 66 ACT FP
PO BOX 711, ADEL 31620
TURNER, JOSEPH M. 66 ACT IM
PO BOX 947, TIFTON 31794
WIGHT, ROBERT P. 66 ACT IM
BOX 947, TIFTON 31793
ZIMMERMAN, CHARLES 66 ACT FP
PO BOX 788, TIFTON 31794
ZIMMERMAN, W.F. 66 ACT FP
801 WEST EIGHTH ST, TIFTON 31794

68—TROUP

ADAMS, JAMES M. 68 ACT IM
PO BOX 828, LA GRANGE 30240
AHN, JUNG HONG 68 ACT AN
747 AZALEA DR, LA GRANGE 30240
ALMAND, JOSEPH M., JR. 68 ACT PD
606 SOUTH GREENWOOD ST, LA GRANGE 30240
AYERS, WILLIAM T., JR. 68 ACT GS
303 SMITH ST, LA GRANGE 30240
BAILEY, A. GLENN 68 ACT GS
303 SMITH ST, LA GRANGE 30240
BAKER, L. DWIGHT, JR. 68 ACT GS
301 MEDICAL DR STE 506, LA GRANGE 30240
BRENNAN, JAMES A. 68 ACT IM
303 SMITH ST, LA GRANGE 30240
BRUCE, JAMES F., JR. 68 ACT ORS
301 MEDICAL DR #505, LA GRANGE 30240
BYARS, STEVENS 68 ACT PH
406 COUNTRY CLUB RD, LA GRANGE 30240
CARTER, RICHARD F. 68 ACT IM,GE
CLARK HOLDER CLINIC, LAGRANGE 30240
CELIS, RODOLFO 68 ACT R
PO BOX 1348, LA GRANGE 30241
CHOI, SUN IK 68 ACT AN
801 CHEROKEE RD, LA GRANGE 30240
COPELAND, ROBERT B. 68 ACT CD
1550 DOCTORS DR STE 301, LA GRANGE 30241
COUSINS, ALBERT L. 68 ACT IM
1550 DOCTORS DR STE 301, LA GRANGE 30241
DOERR, JAMES L. 68 ACT GS
303 SMITH ST, LA GRANGE 30240
DOLAN, JOSEPH A. 68 ACT OBG
303 MEDICAL DR, LA GRANGE 30240
DUTTERA, M. JULIAN, JR. 68 ACT ON
303 SMITH ST, LA GRANGE 30240
EASLEY, CURRAN S., JR. 68 ACT PD
606 SOUTH GREENWOOD ST, LA GRANGE 30240
ESTRADA, MARCELLO A. 68 ACT N
303 MEDICAL DR STE 406, LA GRANGE 30240
FACKLER, WILLIAM B., JR. 68 ACT IM
303 SMITH ST, LA GRANGE 30240
FISHER, GEORGE B. 68 ACT FP
MAPLE ST, FRANKLIN 30217
FLEMING, ANN W. 68 ACT PD
1001 THORNTON RD, 203, LITHIA SPRINGS 30057
GIESLER, GARNETT J., JR. 68 ACT PUD
303 SMITH ST, LA GRANGE 30240
GOLDBERG, AARON S. 68 ACT PD
309 VERNON ST, LA GRANGE 30240
GRACE, KENNETH D. 68 ACT GS
206 CHURCH ST, LA GRANGE 30240
HALL, ARTHUR L. 68 ACT FP
303 SMITH ST, LA GRANGE 30240
HALL, PAMELA P. 68 ACT FP
303 SMITH ST, LA GRANGE 30240
HALL, STANLEY W., JR. 68 ACT OPH
303 SMITH ST, LA GRANGE 30240
HAMMETT, H. HILT, JR. 68 ACT OTO
HAMMETT BLDG, LA GRANGE 30240
HATFIELD, THEODORE R. 68 ACT OM
PO BOX 71, WEST POINT 31833
HENDERSON, WARREN J., JR. 68 ACT IM
303 SMITH ST, LA GRANGE 30240
HENDRICKS, WILLIS M. 68 ACT OBG
303 SMITH ST, LA GRANGE 30240
HINRICHS, MARC B. 68 ACT R
210 BATTLE ST, LA GRANGE 30240
HOLDER, J.S. 68 ACT GS
303 SMITH ST, LA GRANGE 30240
HUBERDEAU, RENE MARC 68 ACT ORS
303 SMITH ST, LAGRANGE 30240
KILLEBREW, JAMES G., JR. 68 ACT ORS
303 SMITH ST, LA GRANGE 30240
KRATINA, FREDRIC K. 68 ACT GYN,P
1550 DOCTORS DR, LA GRANGE 30240
LEBOW, H. GARY 68 ACT OM
PO BOX 71, WEST POINT 31833
LEVERETT, EDWARD 68 ACT FP
303 SMITH ST, LA GRANGE 30240
LIN, GERALD 68 ACT U
303 SMITH ST, LA GRANGE 30240
LINGAM, N.R. 68 ACT EM
1550 DOCTORS DR STE 305, LA GRANGE 30240
LINZ, WERNER A. 68 ACT U
303 SMITH ST, LA GRANGE 30240
LONG, EUGENE ROY 68 ACT IM
CLARK HOLDER CLINIC, LA GRANGE 30240
MA'LUF, TANIOS J. 68 ACT OBG
303 SMITH ST, LA GRANGE 30240
MAJOR, CECIL P. 68 ACT FP
303 SMITH ST, LA GRANGE 30240
MCCLELLAN, WILLIAM M. 68 ACT IM
303 SMITH ST, LA GRANGE 30240
MCCRARY, GEORGE A. 68 ACT ORS
303 SMITH ST, LA GRANGE 30240
MILLER, S. JONES 68 ACT OBG
303 MEDICAL DR STE 403-405, LA GRANGE 30240
MITCHELL, J.T. 68 ACT R
206 PARK AVE, LA GRANGE 30240
MOLYNEAUX, E.W. 68 ACT FP
1550 DOCTORS DR STE 305, LA GRANGE 30240
MORGAN, JAMES C., III 68 ACT OPH
303 SMITH ST, LA GRANGE 30240
MORGAN, JAMES C., JR. 68 ACT OPH
PO BOX 590, WEST POINT 31833
NAIK, MADHAV V. 68 ACT GS
ENOCH CALLAWAY CANCER CTR, LA GRANGE 30240
NORMAN, LEWIS G., JR. 68 R GS
1101 THIRD AVE, WEST POINT 31833
PALMER, E. CAPERS, JR. 68 ACT PTH
819-D MONA LN, LA GRANGE 30240
PLAUCHE', WADE E. 68 ACT R
210 BATTLE ST, LA GRANGE 30240
SABET, REZA M. 68 ACT N
1550 DOCTORS DR, LA GRANGE 30240
SIMPSON, MICHAEL T. 68 ACT CD,IM
BOX 1169, LA GRANGE 30241
SMITH, ROBERT R. 68 R GS
BOX 725, CLAYTON 30525
STANCIL, MELODY ANN 68 ACT AN
1555 DOCTORS DR, LA GRANGE 30240
STICH, JOHN W. 68 ACT PTH
PATHOLOGY DEPARTMENT, LA GRANGE 30240
TURNER, J.R. 68 ACT IM
115 CHURCH ST, LA GRANGE 30240
WAMMOCK, HOKE 68 ACT GS
ENOCH CALLAWAY CANCER CNTR, LA GRANGE 30240
WAMMOCK, VIRGENE S. 68 ACT D
771 LAKEWOOD DR, LA GRANGE 30240
WEST, JOHN THOMAS 68 ACT GS
301 MEDICAL DR ' 503/504, LA GRANGE 30240
WHITEHEAD, C. MARK 68 ACT U
303 SMITH ST, LA GRANGE 30240
WHITEHEAD, C. MARK, JR. 68 ACT U
303 SMITH ST, LA GRANGE 30240
WILKERSON, LESLIE A. 68 ACT OBG
303 SMITH ST, LA GRANGE 30240

69—UPSON

ANTHONY, H.F., JR. 69 ACT R
MEDICAL COLLEGE OF GEORGIA, AUGUSTA 30901
BLACKBURN, J.D. 69 ACT ORS
4 IROQUOIS TRAIL, ORMOND BEACH FL 32074
BREWTON, SAMUEL A., JR. 69 ACT U
206 CHEROKEE RD, THOMASTON 30286
BROWN, BEN S. 69 ACT OBG
PO DRAWER 1166, THOMASTON 30286
CARLAN, STEPHEN J. 69 ACT OBG
PO DRAWER 1166, THOMASTON 30286
DALLAS, R.E. 69 ACT FP
PROFESSIONAL BLDG, THOMASTON 30286
DALLAS, WILLIAM M., JR. 69 ACT GS
405 WEST MAIN ST, THOMASTON 30286
DEEN, JOHNNY T. 69 ACT OPH
230 CHEROKEE RD, THOMASTON 30286
DODGEN, CHARLES WAYNE 69 ACT FP
212 CHEROKEE RD, THOMASTON 30286
GARDNER, NORMAN P. 69 ACT FP
234 CHEROKEE RD, THOMASTON 30286
GOWER, W.J. 69 ACT FP
806 AVALON RD, THOMASTON 30286
HEAD, D.L., JR. 69 ACT FP
PO BOX 591, THOMASTON 30286
HOLLOWAY, ALFRED M. 69 ACT FP
204 CHEROKEE RD, THOMASTON 30286
MIKELL, JOEL E. 69 ACT R
PO BOX 170, THOMASTON 30286
OXFORD, WILLIAM M. 69 ACT GS
405 WEST MAIN ST, THOMASTON 30297
PATRICK, JOHN W. 69 ACT R
131 CHEROKEE RD, THOMASTON 30286
POTITONG, BANLU 69 ACT IM
PO BOX 752, THOMASTON 30286
ROSE, CORDT E. 69 R AN
6 KEELSON LN, SAVANNAH 31411
SHACKLETT, ROBERT S. 69 ACT PTH
PO BOX 1059, THOMASTON 30286
TYLER, HERBERT D. 69 ACT IM
PO BOX 710, THOMASTON 30286
WARNOCK, RALPH PARKS 69 ACT FP
208 CHEROKEE RD, THOMASTON 30286
WOODALL, JAMES A. 69 ACT FP
316 WEST GORDON ST, THOMASTON 30286
WOODALL, WILLIAM P. 69 R FP
316 WEST GORDON ST, THOMASTON 30286

70—WALKER-CATOOSA-DADE

ALISAGO, ANDRES S., JR. 70 ACT AN
7694 EAST BRAINERD RD, CHATTANOOGA TN 37421
BEATTIE, JAMES F., JR. 70 ACT PTH
100 GROSS CRESCENT, FORT OGLETHORPE 30742
CASH, TED D. 70 ACT FP
PO BOX 48, CHICKAMAUGA 30707
COCHRAN, T.A. 70 ACT FP
1215 CLEARVIEW DR, RINGGOLD 30736
CORNWELL, WILLIAM O. 70 ACT FP
2007 OLD LAFAYETTE RD, FT OGLETHORPE 30742
CRAWLEY, WILLIAM D. 70 ACT OBG
787 CHICKAMAUGA AVE, ROSSVILLE 30741
CREEL, JAMES H. 70 ACT EM
TRI-COUNTY HOSPITAL, FT OGLETHORPE 30742
CURTIS, THOMAS H. 70 ACT OBG
744 MCCALLIE AVE, CHATTANOOGA TN 37402
DERRICK, HOWARD C., JR. 70 ACT FP
201 SOUTH MAIN ST, LAFAYETTE 30728
DUHON, FRED J. 70 ACT FP
PO BOX 1066, LAFAYETTE 30728

ELROD, BRUCE A. 70 ACT PTH
PO BOX 2068, FT OGLETHORPE 30742
GOOLSBY, SARA L. 70 ACT AN
211 ANDREWS ST, ROSSVILLE 30741
GREENE, RALPH R. 70 ACT FP
2007 OLD LAFAYETTE RD, FT OGLETHORPE 30742
HAYES, THOMAS E. 70 ACT GS
200 DOCTORS BLDG, FT OGLETHORPE 30742
HILL, DANIEL T. 70 ACT FP
PO BOX 629, TRENTON 30752
HIXSON, JACK D. 70 ACT IM,PUD
MEDICAL PLAZA N STE 504, CHATTANOOGA 37403
HULSE, EDWIN T. 70 ACT OPH
1 THOMAS RD, FT OGLETHORPE 30742
HUTCHISON, NORTON H. 70 R FP
RTE 3 FAIRFIELD PK, SHELBYVILLE TN 37160
ISKANDER, KARIM 70 ACT OBG
PO BOX 578, ROSSVILLE 30741
JONES, ROGER C. 70 ACT IM
150 CROSS CRESCENT, FORT OGLETHORPE 30742
KINARD, GARLAND E. 70 ACT FP
118 HOWARD ST, ROSSVILLE 30741
KITCHENS, S.B. 70 ACT FP
DRAWER A, LAFAYETTE 30728
MAJEED, SHAHUL H.A. 70 ACT OBG
1816 LAFAYETTE RD, FT OGLETHORPE 30742
MARTYNSKI, STANISLAW 70 ACT PD
JL HUTCHESON MEM HOSP, FT OGLETHORPE 30742
MILLS, MARVIN LEON 70 ACT IM
300 DOCTORS BLDG, FT OGLETHORPE 30742
NASSOUR, PAUL A. 70 ACT FP
TRI-COUNTY HOSPITAL, FT OGLETHORPE 30742
PARK, IH KOO 70 ACT GS
200 DOCTORS BLDG, FT OGLETHORPE 30742
POPE, ROY, JR. 70 ACT FP
PO BOX 108, CHICKAMAUGA 30707
RIVENBURG, WILLEM K. 70 ACT IM
150 GROSS CRESCENT, FT OGLETHORPE 30742
SEGARS, JAMES H., JR. 70 ACT GP
PRIMARY HEALTH CENTER, TRENTON 30752
SHAW, GEORGE P., JR. 70 ACT FP
105 EAST PATTON, LAFAYETTE 30728
SIMS, J.P. 70 ACT FP
1 THOMAS RD, FT OGLETHORPE 30742
SMILEY, F. JONES 70 ACT OBG
1816 LAFAYETTE RD, FT OGLETHORPE 30742
SMITH, RICHARD C. 70 ACT FP
PO BOX 967, LAFAYETTE 30728
SMITH, WILLIAM C. 70 ACT FP
2007 OLD LAFAYETTE RD, FT OGLETHORPE 30742
STEPHENSON, CHARLES W. 70 ACT FP
PO BOX 580, RINGGOLD 30736
TERRELL, WARREN 70 ACT AN
PO BOX 10, ROSSVILLE 30741
VASSEY, GEORGE C. 70 R
25 S GERMANTOWN RD, CHATTANOOGA TN 37411
WU, CHUEN-SHIONG 70 ACT PD
790 BATTLEFIELD PKY, FT OGLETHORPE 30742
YOUNG, MARION M. 70 R P,PM
LAFAYETTE MENTAL HEALTH, LAFAYETTE 30728

71—WALTON

COHENOUR, JEFFREY H. 71 ACT PTH
PO BOX 946, MONROE 30655
ENSLEN, PHILLIP J. 71 ACT FP
BOX 866, MONROE 30655
FOSTER, CATHERINE E. 71 ACT OBG
924 WEST SPRING ST, MONROE 30655
HUIE, LYNN M. 71 ACT FP
120 WEST HIGHLAND AVE, MONROE 30655
JAMES, JACK DONALD 71 ACT OBG
333 ALCOVA ST, MONROE 30655
MORELAND, C.C. 71 ACT GP
WALTON CLINIC, MONROE 30655
NEWTON, WILLIAM B. 71 ACT P,CHP
333 ALCOVA ST, MONROE 30655
PORQUEZ, JOSE M.H. 71 ACT GS
PO BOX 191, MONROE 30655
RAO, MEENA 71 ACT US
1401 WEST SPRING ST, MONROE 30655
TANKESLEY, ROBERT M. 71 R R
PO BOX 982, MONTREAT NC 28757

72—WARE

ADKINS, H.T. 72 R PH
807 CHEROKEE CIR, WAYCROSS 31501
BAGLEY, CHARLES E. 72 ACT FP
PO BOX 220, ALMA 31510
BATES, ROGER A. 72 ACT GS
2005 PIONEER ST, WAYCROSS 31501
BATES, W.B., JR. 72 ACT FP
1415 ALICE ST, WAYCROSS 31501
BICKERSTAFF, JAMES W., JR. 72 ACT ORS
1921 ALICE ST, WAYCROSS 31501
BOOKER, DANIEL C., JR 72 ACT ORS,PDS
2002 ALICE ST, WAYCROSS 31501
BROWN, EDWARD B. 72 ACT OBG
PO BOX 177, WAYCROSS 31501
BUTLER, ADRIENNE B. 72 ACT PD
307 PINEVIEW DR, WAYCROSS 31501
BUTLER, JOHN E. 72 ACT GS
1508 TEBEAU ST, WAYCROSS 31501
CALHOUN, W.C. 72 ACT OBS
PO BOX 1945, WAYCROSS 31501
CARBAUGH, ROBERT G. 72 ACT AN
1908 ALICE ST, WAYCROSS 31501
CLARK, S. WILLIAM, JR. 72 ACT OPH
PO BOX 2009, WAYCROSS 31501
COX, DANIEL BAKER 72 ACT IM
2005-C PIONEER ST, WAYCROSS 31501
DANEMAN, E.A. 72 ACT US
2609 PLANT AVE, WAYCROSS 31501
DAVIS, ALFRED L., JR. 72 ACT PD
1406 TEBEAU ST, WAYCROSS 31501
DAVIS, FLOYD E. 72 ACT FP
1921 ALICE ST 1-B, WAYCROSS 31501
DIAL, WILLIAM B. 72 ACT ORS
2002 ALICE ST, WAYCROSS 31501
DUANE, LAWRENCE, JR. 72 ACT R
PO BOX 938, WAYCROSS 31501
DURRENCE, LEONARD C., JR. 72 ACT FP
PO BOX 231, BLACKSHEAR 31516
EDDINGS, TALLY H., II 72 ACT
228 RIVERSIDE DR, WAYCROSS 31501
FERRELL, T.J., JR. 72 ACT IM
1921 ALICE ST, WAYCROSS 31501
FLESCH, W.L. 72 R U
RTE 2 BOX 57, TOWNSEND 31331
GRIFFIN, HOWARD A., JR. 72 ACT R
PO BOX 938, WAYCROSS 31501
HEATH, GEORGE S. 72 ACT FP
PO BOX 1909, WAYCROSS 31501
HEATH, HEZEKIAH K., JR. 72 ACT US
PO BOX 1909, WAYCROSS 31501
HENDRY, KATHERINE M. 72 R FP
PO BOX 408, BLACKSHEAR 31516
HOLLOWAY, JOHN T. 72 ACT GP
1101 CHURCH ST, WAYCROSS 31501
HOWARD, PEGGY J. 72 R OBG
3296 CENTRAL AVE, WAYCROSS 31501
JACOBS, IVEY 72 ACT OTO
PO BOX 882, WAYCROSS 31501
JACOBS, L. DAVIS 72 ACT FP
PO BOX 156, WAYCROSS 31501
KILARI, SWAMY 72 ACT IM,CD
1921 ALICE ST STE 3-B, WAYCROSS 31501
KO, KWANG BIN 72 ACT AN
1908 ALICE ST, WAYCROSS 31501
LEE, WALTER E., JR. 72 ACT FP
BOX 737, WAYCROSS 31501
LEWIS, WILEY B. 72 ACT OS
1507 ALICE ST, WAYCROSS 31501
LOPEZ, ERNESTO G. 72 ACT PTH
WAYCROSS MEMORIAL HOSPITAL, WAYCROSS 31501
LOTT, DAN A. 72 ACT OBG
700 RIVERSIDE AVE, WAYCROSS 31501
LYNCH, DONALD RICHARD 72 ACT FP
1514 ST MARYS DR, WAYCROSS 31501
MALMBORG, JOHN C. 72 ACT OBG
1404 TEBEAU ST, WAYCROSS 31501
MARAMREDDY, KRUPAVATBI 72 ACT PD
1921 ALICE ST, WAYCROSS 31501
MARAMREDDY, P. 72 ACT IM
415 ALBANY AVE, WAYCROSS 31501
MARTINEZ, JOSEPH 72 ACT AN
MEMORIAL HOSPITAL, WAYCROSS 31501
MCCLARIN, WILLIAM M., JR. 72 ACT D
202 FOLKS ST, WAYCROSS 31501
O'CONNELL, MICHAEL J. 72 ACT ORS
2507 ALICE ST, WAYCROSS 31501
ODEN, LEWIS H., JR. 72 R GP
PO BOX 149, BLACKSHEAR 31516
PACKER, ROBERT M., III 72 ACT IM
PO BOX 899, WAYCROSS 31501
PACKER, ROBERT M., JR. 72 ACT IM
PO BOX 899, WAYCROSS 31501
POMEROY, W.L. 72 ACT GS
1421 ST MARYS DR 40970-A, WAYCROSS 31501
POMEROY, WILLIAM L., JR. 72 ACT IM
PO BOX 1889, WAYCROSS 31501
ROORIGUEZ, ANA G. 72 ACT AN
1908 ALICE ST, WAYCROSS 31501
RUTLEDGE, JOHN H. 72 ACT OBG
2005-D PIONEER ST, WAYCROSS 31501
SAWYER, JAMES L. 72 R P
1515 CHEROKEE DR, WAYCROSS 31501
SHEPARD, JACK N. 72 ACT OBG
PO BOX 280, ALMA 31510
SHUMAN, VILDA 72 ACT PD
520 BUNN BLDG, WAYCROSS 31501
SMITH, LEO 72 ACT OTO
1507 ST MARYS DR, WAYCROSS 31501
SMITH, ROBERT C. 72 ACT R
PO BOX 938, WAYCROSS 31501
STEBLER, MICHAEL E. 72 ACT PTH
MEMORIAL HOSPITAL, WAYCROSS 31501
TAYLOR, JAMES W. 72 ACT OPH
304 RIVERSIDE DR, WAYCROSS 31501
TERRY, DANIEL B., JR. 72 ACT FP
1508 TEBEAU ST, WAYCROSS 31501
THOMAS, BRENDA H. 72 ACT PD
307 PINEVIEW DR, WAYCROSS 31501
THOMPSON, CLEVELAND, III 72 ACT GS
303 PINEVIEW DR, WAYCROSS 31501
TOMLINSON, RONALD L. 72 ACT U
BOX 2007, WAYCROSS 31501
TRIANA, CARLOS R. 72 ACT GS
PO BOX 337, PATTERSON 31557
VICTOR, SAMUEL 72 ACT FP
1010 SEMINOLE TR, WAYCROSS 31501
WATERS, DONALD B. 72 ACT FP
PO BOX 369, BLACKSHEAR 31516
WILLIAMS, ROYCE MAHONE 72 ACT OBG
3531 BOONE PARK AVE, JACKSONVILLE FL 32205
WYNN, O.C. 72 ACT FP
861 FOLKS ST, WAYCROSS 31501
YEOMANS, NEAL F. 72 R R
704 MAGNOLIA ST, WAYCROSS 31501
ZARZUELA, RICARDO I., JR. 72 ACT FP
1408-B TEBEAU ST, WAYCROSS 31501
ZORN, DONALD A. 72 A US
TLHASSE MEM REG MED CTR, TALLAHASSEE 32308

74—WASHINGTON

HARVEY, LOUIS R. 74 ACT FP
PO BOX 383, SANDERSVILLE 31082
HELTON, WILLIAM S. 74 ACT FP
522 WASHINGTON AVE, SANDERSVILLE 31082
HURT, MARION W. 74 R FP
512 WASHINGTON AVE, SANDERSVILLE 31082
RAWLINGS, WILLIAM 74 ACT FP
522 WASHINGTON AVE, SANDERSVILLE 31082
RAWLINGS, WILLIAM, JR. 74 ACT IM
522 WASHINGTON AVE, SANDERSVILLE 31082
TAYLOR, WILLIAM E. 74 I&R FP
PO BOX 386, TENNILLE 31089
TRAER, JON W. 74 ACT GS
522 WASHINGTON AVE, SANDERSVILLE 31082
WARD, JOHN R. 74 ACT GS
522 WASHINGTON AVE, SANDERSVILLE 31082

75—WAYNE

AMSTER, STEVEN M. 75 ACT AN
WAYNE MEMORIAL HOSP BOX 408, JESUP 31545
BRANTLEY, JAMES W. 75 ACT GS
PO BOX 1133, JESUP 31545
ELLIOTT, PAUL M. 75 ACT FP
PO BOX 937, JESUP 31545
HARRELL, E.L. 75 ACT US
RTE 4 BOX 424, JESUP 31545
HILLIS, CHARLES L. 75 ACT EM,FP
PO BOX 408, JESUP 31545
MCGAHEE, OLLIE O., JR. 75 ACT FP
PO BOX 937, JESUP 31545
MEGUIAR, RAMON V. 75 ACT OBG
PO BOX 1373, JESUP 31545
MILLER, ROBERT E. 75 ACT FP
PO BOX C, JESUP 31545
PHILLIPS, ROBERT L. 75 ACT FP
PO BOX 937, JESUP 31545
PUMPELLY, ROBERT A. 75 ACT FP
166 MEMORIAL DR, JESUP 31545
PURSER, ALVIN D. 75 ACT FP
PO BOX 937, JESUP 31545
SPOTTSWOOD, PAUL G. 75 ACT AN
PO BOX 408, JESUP 31545
YEOMANS, JAMES W. 75 ACT GS
PO BOX 67, JESUP 31545

76—WHITFIELD-MURRAY

BAILEY, PHILIP B. 76 ACT CD
1217 MEMORIAL DR, DALTON 30720
BARNWELL, WILLIAM L. 76 ACT OPH
1111 PROFESSIONAL BLVD, DALTON 30720
BENSON, JOY F. 76 ACT PH
BRYANT CROSSING, DALTON 30720
BESTAWROS, ONSY A. 76 ACT R
PO BOX 1285, DALTON 30720
BLACKMAN, WILLIAM M. 76 ACT OPH
1111 PROFESSIONAL BLVD, DALTON 30720
BLACKWELL, JAMES COLLIER 76 ACT IM
1308 MEMORIAL DR, DALTON 30720
BOGGESS, NEIL D., JR. 76 ACT FP
1012 BURLEYSON DR, DALTON 30720
BOOKOUT, MARK W. 76 ACT OTO
1436 BROADRICK DR, DALTON 30720
BOOZER, ALBERT MARION 76 ACT FP
1109 BURLEYSON DR, DALTON 30720
BOYD, GLENN H. 76 ACT IM
1203 MEMORIAL DR, DALTON 30720
BRADLEY, PAUL L. 76 ACT GS
PO BOX 1969, DALTON 30720
BURNS, ROBERT A. 76 ACT GS
1109 BURLEYSON DR, DALTON 30720
BUTT, JAVED A. 76 ACT IM
1217 MEMORIAL DR, DALTON 30720
CARSON, W.P. 76 ACT GS
PO BOX 129, DALTON 30720
CHURCH, JOHN C. 76 ACT DR
PO BOX 2339, DALTON 30720
DARDIN, M. VICTOR 76 ACT OBG
PO BOX 989, DALTON 30720
EASLEY, CONRAD H. 76 ACT ORS
1103 MEMORIAL DR, DALTON 30720
EIDSON, RODGER H. 76 ACT OBG
1109 BURLEYSON DR STE A, DALTON 30720
FARROW, ROYAL T. 76 ACT PD
1109 BURLEYSON DR, DALTON 30720
FELKER, FORT F., JR. 76 ACT FP
216 NORTH PENTZ ST, DALTON 30720
FORSHNER, JOHN G. 76 ACT D
1206 WEST WAUGH, DALTON 30720
FRADY, ROBERT P. 76 ACT OTO
5161 PUTNAM RD, COHUTTA 30710
FROMM, STEFAN H. 76 ACT GS
PO BOX 1969, DALTON 30720
GIDDENS, RICHARD D. 76 ACT GS
1109 BURLEYSON DR, DALTON 30720
GILBERT, CARL N. 76 ACT PD
1109 BURLEYSON DR, DALTON 30720
GREGORY, JAMES R. 76 ACT OBG
1109 BURLEYSON DR STE A, DALTON 30720
HARRISON, JACOB R., JR. 76 ACT OBG
1108 PROFESSIONAL BLVD, DALTON 30720
HENSON, PAUL E., JR. 76 ACT U
1109 BURLEYSON DR, DALTON 30720
HODGES, FRED BARRY, III 76 ACT ORS
1103 MEMORIAL DR, DALTON 30720
JAMES, FLOYD 76 ACT PTH
PO BOX 1168, DALTON 30720
JONES, J. SHERWOOD 76 ACT IM
1209 MEMORIAL DR, DALTON 30720
LANCASTER, CARLTON D., JR. 76 ACT IM
1209 MEMORIAL DR, DALTON 30720
LULL, CHARLES ROBERTS 76 ACT R
PO BOX 2066, DALTON 30720
LUMPKIN, MURRAY B. 76 ACT GS
PO BOX 987, DALTON 30720
LUMPKIN, WILLIAM H. 76 ACT GS
PO BOX 987, DALTON 30720
MAHAN, D.R., JR. 76 ACT FP
1219 MEMORIAL DR, DALTON 30720
MARLOW, JAMES E. 76 ACT FP
1714 CLEVELAND AVE, DALTON 30720
MARTIN, H.U. 76 ACT R
PO BOX 1285, DALTON 30720
MAXWELL, THERESE A. 76 ACT IM
PO BOX 1924, DALTON 30720
MCDANIEL, WILLIAM L., JR. 76 ACT FP
1114 PROFESSIONAL BLVD, DALTON 30720
MCGHEE, EARL T. 76 ACT FP
1012 BURLEYSON DR, DALTON 30720
MCKINNEY, JAMES E. 76 ACT U
1109 BURLEYSON DR, DALTON 30720
METCALFE, JAMES K. 76 ACT CLP
PO BOX 1168, DALTON 30720
MYERS, JAMES S. 76 ACT R
PO BOX 1285, DALTON 30720
PATEL, HASMUKH R. 76 ACT IM,GE
1217 MEMORIAL DR STE 2, DALTON 30720
PILCHER, JAMES WRIGHT, JR. 76 ACT IM
1203 MEMORIAL DR, DALTON 30720
POEHLMAN, JOHN HOWARD 76 ACT IM
1436 BROADRICK DR, DALTON 30720
RAITZ, ROBERT L. 76 ACT FP
1012 BURLEYSON DR, DALTON 30720
REDFEARN, JAMES A., JR. 76 ACT IM
1209 MEMORIAL DR, DALTON 30720
RICHMOND, JOHN D. 76 ACT IM,NEP
1406 BROADRICK DR, DALTON 30720
SANDERS, DRAYTON M. 76 ACT
1217 MEMORIAL DR, DALTON 30720
SANDERS, J. LARRY 76 ACT OBG
1108 PROFESSIONAL BLVD, DALTON 30720
SANDVI, M. ASLAM 76 ACT P
PO BOX 1648, DALTON 30720
SAPP, PHILIP B. 76 ACT EM
PO BOX 98, ROCKY FACE 30740
SELLERS, SIDNEY L. 76 ACT GYN
PO BOX 989, DALTON 30720
SHERRILL, REGINALD R. 76 ACT PS
1111 PROFESSIONAL BLVD, DALTON 30720
SHIRLEY, RUDY M. 76 ACT OTO
1436 BROADRICK DR, DALTON 30720
SIMMONS, ROBERT W. 76 ACT FP
1114 PROFESSIONAL BLVD, DALTON 30720
SPANJER, RAYMOND F. 76 ACT FP
7400 SW 209 COURT RD, DUNNELLON FL 32630
SPANJER, RICHARD F. 76 ACT PD
1109 BURLEYSON DR, DALTON 30720
STROPNICKY, ELIZABETH 76 ACT OBG
1108 PROFESSIONAL BLVD, DALTON 30720
SUMMEROUR, BROOKE F. 76 ACT AN
821 ATKINSON DR, DALTON 30720
SUTTER, LUTHER O. 76 ACT FP
PO BOX 709, CHATSWORTH 30705
TAMAYO, ELMO R. 76 ACT FP
OLD ELLIJAY RD, CHATSWORTH 30705
THOMAS, DONALD RAY 76 ACT FP
1714 CLEVELAND RD, DALTON 30720
VIAMONTE, LUIS M. 76 ACT PD
BURLEYSON DR, DALTON 30720
WAGES, HARVEY S., JR. 76 ACT OBG
1109 BURLEYSON DR STE A, DALTON 30720
WALUS, MICHAEL A. 76 ACT NS
1207 MOICE DR, DALTON 30720
WEEKS, WALLACE R. 76 ACT FP
1012 BURLEYSON DR, DALTON 30720
WELLS, DAVID A. 76 ACT FP
1219 MEMORIAL DR, DALTON 30720
WHITE, JEFFEORY H. 76 ACT PD
1217 MEMORIAL DR, DALTON 30720
WHITFIELD, T.W. 76 ACT FP
1221 MEMORIAL DR, DALTON 30720
YU, FRANK 76 ACT AN
1700 ANTHONY AVE, DALTON 30720

78—WILKES

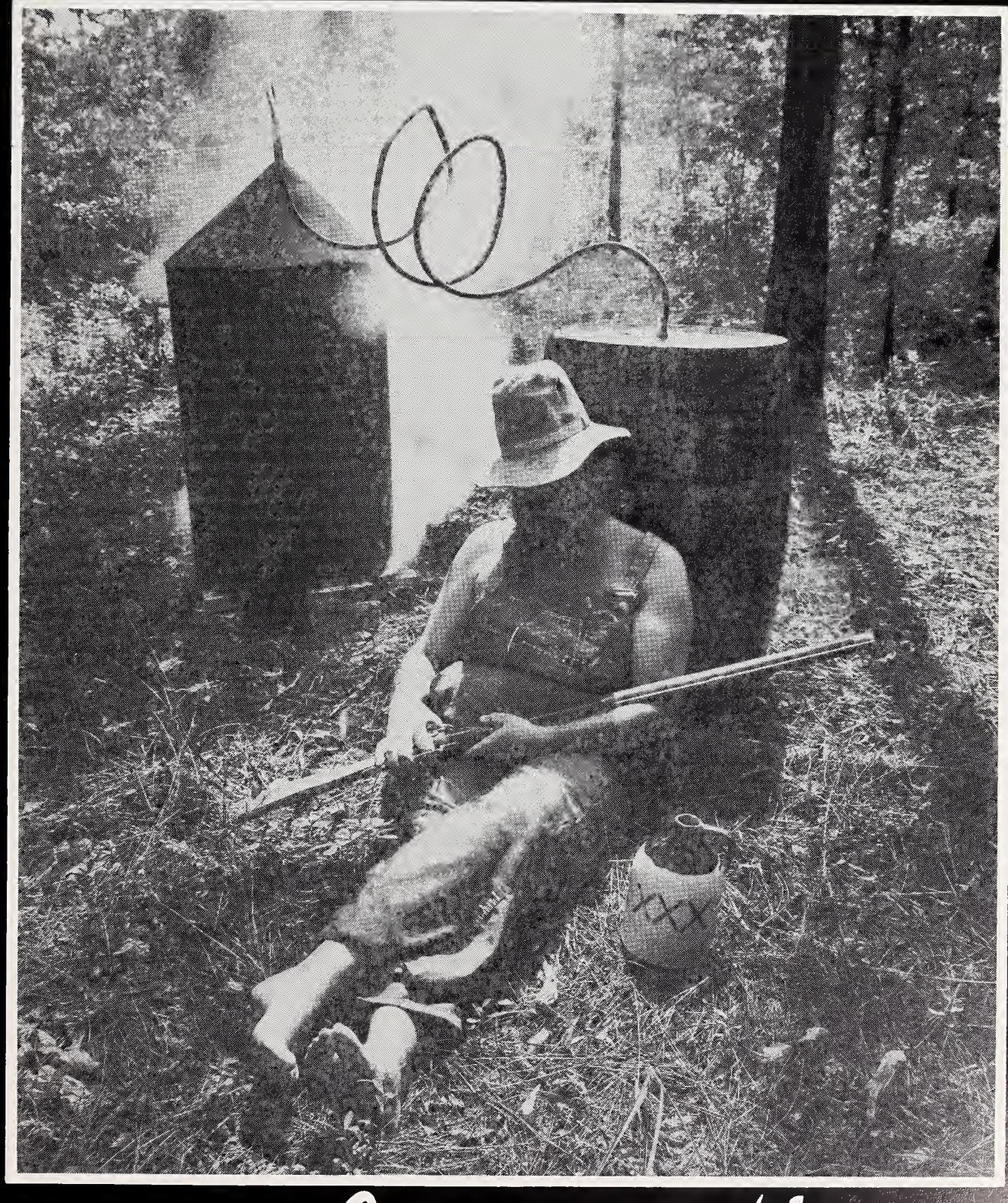
ADAIR, M.C. 78 R FP
203 SIMS ST, WASHINGTON 30673
BAMFORD, SOPHIA 78 ACT PTH
119 GORDON ST, WASHINGTON 30673
MCMAHAN, HOWARD C. 78 ACT FP
212 HOSPITAL DR, WASHINGTON 30673
POLLOCK, C. EUGENE 78 ACT GS
123 GORDON ST, WASHINGTON 30673
POLLOCK, JOHN EDWARD, JR. 78 ACT FP
123 GORDON ST, WASHINGTON 30673
WILLS, C.E., JR. 78 ACT FP
119 GORDON ST, WASHINGTON 30673

79—WORTH

DAVIS, H.G., JR. 79 ACT FP
PO BOX 405, SYLVESTER 31791
EASON, HARMER O., JR. 79 ACT IM
501 WESTBERRY ST, SYLVESTER 31791
MCLEAN, FREDERICK L. 79 ACT FP
407 MCPHAUL ST, SYLVESTER 31791
PARK, JUNESEOK 79 ACT GS
310 NORTH WESTBERRY ST, SYLVESTER 31791
PIERZCHAJLO, RICHARD P.J. 79 ACT FP
BOX 7010, TIFTON 31794

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